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MENTAL HYGIENE

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Articles

Book Reviews

WINFRED OVERHOLSER, M.D., Sc.D.

The volunteer in psychiatric rehabilitation

One of the recent developments in the rehabilitation of the mentally ill has been the expanding use of volunteer workers. Starting with the Gray Ladies of the American Red Cross who served primarily in the Veterans Hospitals, their use in public institutions has grown to such an extent that hardly a well-organized mental hospital today is without a program of volunteer work. This fact is a reflection of several changed attitudes.

In the first place there has been a recognition by the administrators of hospitals that volunteers can play a very useful part in the rehabilitation of the patient. In part, perhaps, this has been due to the fact that personnel shortages have caused a further appraisement of the possibilities of such service. But I think it goes much further than that. While a marked change in the whole atmosphere of mental institutions has been going on, there has at the same time developed a realization that they are an integral part of the community and that it is important that the community should realize this fact. There is growing, too, a widespread public recognition of the past failures of governmental authorities to give adequate support to the mental hospitals and a realization as well that these institutions, far from being bedlams and places of despair, are facilities for the treatment of persons who are ill and who can be helped. The old attitudes of the public toward the mentally ill and toward the inmates of what were once called asylums has changed markedly, thanks to the campaign of public education which has been carried on by the National Association for Mental Health and the local mental health societies. Progress certainly has been made in the line of public understanding of the nature of mental illness, of its treatability and of the fact that the

Dr. Overholser is Superintendent, Saint Elizabeths Hospital, U.S. Department of Health, Education and Welfare, Washington, D. C.

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many patients who leave the hospitals must be reassimilated as members of society. Thus we find greater readiness on the part of employers to use expatients and on the part of families and friends to accept them. We find a greater freedom within the hospital and a greater attitude of hope and encouragement. These have been stimulated, in part, by some of the recent forms of treatment, notably the concept of the hospital as a therapeutic community and the valuable aid given by the development of tranquilizing drugs.

Let us speak first of the value of the volunteer to the hospital and to the patient. All too often the patient in the mental hospital feels isolated, removed from the community, cut off from contacts with the outside world. He may realize that the doctors and the nurses are interested and are attempting to help him, but after all they are a part of the system and to him they must seem at least somewhat impersonal. Now comes the volunteer, a person from the outside world, not seeking glory or financial return. The volunteer brings to the patient an interest, an altruistic interest, a reassurance that persons not dependent for their livelihood upon the institution are interested in him. The patient finds, too, that the volunteer is not afraid and that the community she represents is not afraid of the hospital and of him but rather that he, the patient, is still of interest to his former associates and to the world from which he came. This constitutes reassurance, a bolstering of his ego, a realization that he is not forgotten or isolated. This gift of unselfish interest from the outside world cannot be replaced; it is unique and extremely valuable to the patient. To the staff of the hospital the volunteer, by his presence, brings the knowledge that the public is interested in supporting the work of the hospital.

I speak of these general aspects quite aside from the specific services which the volunteer renders. These latter, however, are many. The volunteer brings to the patient special skills and talents which might not otherwise be available, but her services should never become a substitute for the work of the regular staff of the hospital, great as that temptation may be to the administration of the hospital. She represents something added, the frosting on the cake, so to speak; and what is cake without frosting? The volunteer must, of course, work closely with the staff and under their general supervision. She should understand what the staff is trying to do, how they do it and the demands of hospital etiquette. The reverse is equally true: namely, that the staff must understand the possible contributions of the volunteer service, appreciate them and be ready to cooperate.

The variety of services which the volunteer can render, either to individuals or to groups of patients, is almost infinite. One thinks of art classes, of dance and music therapy, of classes in typing and languages, history, current events, and cooking, lectures on special topics, the development of clubs such as those devoted to chess or to stamps and the operation of such service activities as beauty parlors and "apparel shops." One type of service our volunteers have developed at Saint Elizabeths Hospital has been that to the blind patients. The volunteers read to groups of blind patients, write letters for them and play "talking book" records for them, the titles being selected by the patients themselves. Again, in connection with the library services, books are distributed to the wards and book reviews are arranged or given by the volunteers. Some of these activities are primarily cultural, but others, such as typing, may be distinctly utilitarian and prevocational. As for groups, various activities in the recreational and athletic line, ball games, trips to the symphony concerts and other entertain-

ments may be developed. Other valuable activities of volunteers include acting as receptionists or as aides in the hospital record room. Groups of volunteers, particularly those from church organizations or other service organizations such as the American Legion and the Kiwanis, may bring group entertainments or hold parties on the wards. All of these are valuable and they all mean much to the patients. These activities, too, promote the resocialization of the patient, our ultimate aim. Not only do they result in the maintenance of his interest in outside activities; they also give him what is even more valuable—a feeling of hope.

The importance of these services is a qualitative one and can never fully be measured by figures as to the number of hours or the number of persons involved, significant as these well may be. In speaking of the values of a volunteer service to the hospital, two comments should be made in the nature of a caution. One is that any program of this sort must be desired rather than merely tolerated by the administration of the hospital. More and more administrators of hospitals are coming to realize the values which such a program can render to the hospital and to the patient. I am sure that in cases where some reservations have been experienced at first, those administrators, to quote Oliver Goldsmith, "who came to scoff remained to pray." The other caution which I would utter has to do with the selection of volunteers. It is a fact that not every person is entirely suitable by temperament or make-up to serve as a volunteer, and sometimes the motivation is not all that could be desired. There are persons who are seeking a solution to their own problems or who have a morbid curiosity about what goes on in the mental hospital. A certain amount of selection therefore is necessary, as is a program of orientation to the nature of mental illness, to the operation of the hospital and to the services which can be rendered. I have no doubt whatever from personal experience, from observation and others' testimony of the great value a well-directed volunteer program can render to the personnel, but more particularly to the patient and to the institution as a community organization.

What does service in a hospital do for the volunteer?

First of all she learns about mental illness and about the various forms of treatment, what goes on in the hospital and what the doctors and nurses do. She learns, too, that mental patients are not substantially different from the people she knows outside, that they are not of a special order of creation but that they are human beings with their own problems who value, as do all of us, a friend who is a sympathetic listener. The volunteer learns much not only of the problems but of the courage of the patients and of the devotion of the doctors and the nurses to the welfare of those patients. She learns the need for poise and for good humor, the need for observing hospital etiquette and, above all, the need for discretion in discussing the affairs of others. She learns, as does the newly graduated doctor, the cardinal rule of not discussing patients, either with other patients or with her friends outside the hospital. She sees for herself that the hospital is a place not of despair, of clanking chains and of padded cells, but that it is a place where patients have a very considerable amount of freedom, where the atmosphere is one of friendliness and of hope and of an expectation that the patient will return to his former activities.

The volunteer is in an excellent position to develop in her friends and associates a sound attitude towards mental illness and to disabuse their minds of the many prevalent misconceptions of mental illness and

of mental hospitals. She learns from her personal experience that many patients recover and return to their former occupations and to their families. Indeed, she may learn to understand somewhat better than she did before the foibles and the crotchets of her friends, for after all, as William James pointed out long ago, there is no better place to learn about human nature than from the patients in the mental hospital. All this knowledge should be, and is, of value to the volunteer in making her a more useful member of the community and perhaps even bringing to her a somewhat better appreciation of her own possibilities and her own personality make-up.

I have spoken of the value of volunteer service to the hospital and the learning process of the volunteer. There is another value to which I may refer as the spiritual. It is one of the glories of our democratic society that throughout its history there have been many persons who were glad to be of service to the less fortunate. It is no accident, I think, that the earliest hospitals in this country, both general and mental, were organized and operated by philanthropic men and women in the community, not by local or state governments. The earliest mental hospitals of the United States were, for example, The New York Hospital, The Pennsylvania Hospital, followed closely by The Massachusetts General Hospital, The Hartford Retreat, to name only a few. They represented the philanthropy of their day, the generosity of persons who gave of their means to care for those who were not able to care for themselves. One thinks, for example, of the magnificent and self-sacrificing contributions of persons like Clara Barton, Dorothea Lynde Dix, Samuel Gridley Howe and Albert Schweitzer, the foundations established by such men as Andrew Carnegie, Ford and the Rockefellers. The whole Community Chest movement is an exemplification of this readiness to help the less fortunate.

It is characteristic of a democracy, particularly of a prosperous one like ours, that in it private generosity thrives both in the form of financial contributions and of service to others. This ideal of service to others is similarly, although not exclusively, one of the Judeo-Christian virtues. There *is* such a thing as altruism. It is a source of lasting satisfaction to give of oneself and to realize that one's efforts have been helpful to others. One of the great contributions of Sigmund Freud is his emphasis on the fact that it is only by giving love that one can experience it. This is one of the basic truths of mental health and of a true satisfaction in living. The idea of the dedicated volunteer is expressed in the words of Jesus and is the favorite Biblical verse of Dorothea Lynde Dix, the greatest champion of the mentally ill that this country has produced:

> "Inasmuch as ye have done it unto one of the least of these, My brethren, ye have done it unto Me."

I have spoken of the value of the volunteer to the mental hospital and to its patients and of the value to the volunteer of her service to them, both intellectually, emotionally and spiritually. Perhaps what I have been trying to say on this latter score is well-summarized by James Russell Lowell in the closing lines of *The Vision of Sir Launfal:*

> "The Holy Supper is kept, indeed,
> In whatso we share with another's need;
> Not what we give, but what we share,
> For the gift without the giver is bare;
> Who gives himself with his alms feeds three,
> Himself, his hungering neighbor, and Me."

HARVEY E. WOLFE, M.Ed.

A survey of vocational rehabilitation at Longview State Hospital for 1959

With the advent of new drugs and consequent shorter treatment necessary to reduce emotional disability and its residuals, a comprehensive vocational rehabilitation program becomes increasingly important. Longview State Hospital has had fragmentary and sporadic VR programs since about 1950. A VR department to provide comprehensive services was instituted by a directive of the superintendent in 1958; thus, 1959 represents the first calendar year of operation. By 1959 the VR department had a director, a counseling psychologist, a rehabilitation counselor (acting as a work therapy supervisor) and clerical help.

It was felt that service by VR should begin with patients as soon as they were psychiatrically ready for grounds privileges. At this time they are evaluated for possible work therapy assignments according to their abilities, interests and needs. Goals sought are the establishment of work-social skills, development of work tolerance, re-establishment of skills lost by disuse, or the development of basic vocational skills. Patients not motivated or not having adequate initial work tolerance for this program can profit greatly from an occupational therapy-activity prescription, according to their individual needs. This should be designed to provide prevocational experience. Hopefully, many patients can move up through the activity experience to a work therapy setting, and from here to outside employment.

The average state hospital has many resources for setting up a workable work therapy program (6). Table 1 shows the

Mr. Wolfe is Director of Vocational Rehabilitation at Longview State Hospital and Lecturer in Psychology at Xavier University, Cincinnati, Ohio.

TABLE 1

Total work therapy assignments (For an average month in 1959)

Barber Shops	2
Beauty Parlor	17
Bowling Alley	2
Broom Shop	9
Commissary	35
Dietary	
Bakery	1
Butcher Shop	3
Hospital Kitchens and Dining Rooms	186
Farm	
Greenhouse	4
Grounds	33
General Clerical	10
Housekeeping	180
Laboratory	2
Laundry	123
Mattress Shop	12
Maintenance	
Electric Shop	1
Machine Shop	6
Masonry	9
Truck Deliveries	17
Stock Room	1
Handyman	10
Print Shop	5
Post Office	6
Power House	11
Sewing Room	1
Store Room	10
Total	696

work therapy make-up by areas for an average month (May, 1959).

Most state hospitals are understaffed to the point of having to rely, at least to some extent, on patient labor. This is not inconsistent with the development of a highly useful work therapy program. The patient's needs can still come first, and through good inhospital education and sound two-way communications a surprising amount of staff interest can be generated in making work therapy serve the patient as well as the hospital.

Through the team operation of physician, VR specialist, work supervisor and other disciplines, work assignments can become a significant and highly useful part of the patient's total treatment program. The patient can be observed and assisted in making an adequate work adjustment. Clews gathered here can play an important part in determining his level of functioning with reference to the outside world. Table 2 shows the work therapy assignments of patients prior to placement in outside employment in 1959.

TABLE 2

Work therapy assignments prior to job placements

Beauty Parlor	3
Commissary	16
Dietary	
Butcher Shop	2
Hospital Kitchen and Dining Rooms	11
Farm	
Grounds	1
General Clerical	11
Housekeeping	25
Laboratory	2
Laundry	4
Mattress Shop	2
Maintenance	
Electric Shop	1
Machine Shop	2
Masonry	2
Truck Deliveries	2
Handy Man	1
Post Office	1
Sewing Room	2
Store Room	1
Total	89

The patient population consisted, to a major degree, of people formerly doing unskilled labor and often lacking both the ability and interest for progression to a higher vocational level. In the present labor market these people often presented difficult placement problems.

Verbal and written information is gathered on the patient in the work therapy area and this becomes the beginning of his cumulative record with the VR department. The information gleaned is shared with the physician and other disciplines, and when it is felt that the patient is ready, the physician signs a referral to VR for training or outside placement activities. Resources of outside agencies, such as sheltered workshops, the Ohio Bureau of Vocational Rehabilitation, etc., are used where applicable. Effort is made to avoid duplication of services available elsewhere. The Ohio Bureau of Vocational Rehabilitation, e.g., will sponsor individual training programs, where they are needed, if the patient meets their criteria of eligibility. At Longview, the majority of patients requiring VR services need counseling, specialized placement assistance and the opportunity to develop work tolerance. Training, in the sense of learning a new trade, has not been found profitable for many adult patients served by this hospital. The regaining of former skills and development of good work tolerance seem to be the major needs in this area.

Considerable research is being done on employer attitudes toward hiring of exmental patients, and our findings (1, 7) agree with other reports (3) that the employer's expressed attitudes are not nearly so unfavorable as generally believed. We are presently determining how well these expressed attitudes will correlate with actual placement results. It is too early to make firm statements, although the correlation so far seems high. Continuous programs for community information and education about mental illness are greatly needed.

The VR department employs any special testing necessary for the efficient vocational evaluation of the patient and incorporates these results into the cumulative record.

Results of outside job placement activity for 1959 are shown in Table 3. The VR department played an evaluative, work therapy and supportive role in many more cases than those requiring substantial placement activity.

When the patient is ready, his individual efforts (with counseling) toward finding employment are encouraged. We do not feel

TABLE 3

A. Types of competitive job placements

Industrial—Manufacturing	14
Office—Stenographic—Clerical	7
Retail Stores	14
Distributor—Jobber	1
Hotels	2
Institutions	10
Nursing Homes	18
Children's Home	1
Laborer	10
Service Occupations—Restaurants	2
Domestic	16
(Male 40—Female 55) Total	95

B. Sheltered placements

Sheltered Workshops	5
Grand Total	100
Less Duplications	11[1]
Individual Patients Placed	89

[1] *Some patients successfully placed had to return to the hospital but were well enough to place again during the same year.*

that the patient should be "led by the hand," although support should be available as required. Of the 89 individual placements made, 73 (82 per cent) are still successfully employed as of this writing. Sixteen (18 per cent) of the placements were unsuccessful. Based on information we were able to accumulate, seven of these were found psychiatrically unready; four lacked adequate motivation; and five were unsuitably placed. Patients are regularly followed up (within the limits of staff size) through convalescent status and discharge. The weekly pay range for the patients returned to competitive employment was from $40 to $100.

Many patients with very poor prognoses passed through the VR program to successful competitive employment (55 were schizophrenics; 13 had character disorders; and 21, other psychotic conditions). Although the expected tendency of easier re-employment for the patient with short-term hospitalization holds true, considerable inroads were made with long-term patients. A patient with 25 years of continuous hospitalization was returned to work in 1958. The distribution of the 89 individual job placements by length of hospitalization was: less than 1 year, 26; 1 to 5 years, 32; 5 to 10 years, 20; more than 10 years, 11.

Patients who are employed may live in the hospital for a time if it is thought to be of psychiatric value. As yet, we have no formal night hospital.

A Member-Employee Program, we recognize, could add much to the resources we are already using since its values are coming to be well-recognized (5). Approximately 175 patients are remunerated for work in a range from $5 to $45 per month.

If any comprehensive VR program is to succeed, it must involve a continuous, meaningful experience for the patient, hospital staff and the community. The active co-operation and participation of all disciplines is necessary for the rehabilitation of patients. Total rehabilitation includes psychiatric, social and vocational rehabilitation, and these three phases operate interdependently (2). As Dr. Peter Peffer clearly put it: "All hospital employees participate in the treatment of patients. This includes administrative, maintenance, custodial, hospital aides and other personnel as well as the professional staff. All employees are potential therapists and may exert therapeutic influence on patients through their relationships with them. . . . Rehabilitation activities must be integrated with the overall treatment program. All therapeutic activities are interdependent and part of a team effort" (4).

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THOMAS S. SZASZ, M.D.

Hospital-patient relationships in medicine and psychiatry

INTRODUCTION

The relationship between physician and patient has been of interest to a variety of workers in medicine and the behavioral sciences. In recent decades, physicians, psychotherapists, psychologists, sociologists, social workers and others have scrutinized this relationship and have contributed to an understanding of it. Indeed, the doctor-patient relationship probably has constituted the most significant link among the activities of the diverse health-promoting agencies of our modern society (5, 20).

The analogous relationship between hospitals and patients, which I propose to describe and analyze in this essay, has received considerably less attention. This study will be limited to an examination of contemporary American hospital-patient relationships.[1] More specifically, my purpose is to clarify some aspects of mental hospital practices by contrasting them with medical hospital and prison practices.

MODELS OF MEDICAL HOSPITALS

Let us begin by listing the principal types of medical hospitals. Included in this category are general and special hospitals devoted to caring for patients with medical, surgical, orthopedic, obstetrical, pediatric and other medical problems. These must be distinguished from psychiatric hospitals: that is, institutions designed to care for the needs of so-called mental patients. Medical hospitals may be divided into groups according to characteristic hospital-patient relationships. The following four groups can readily be distinguished: 1. Private hospital—paying patient; 2. Public hospital—charity patient; 3. Military hospital—serv-

Dr. Szasz is associated with the Department of Psychiatry, State University of New York Upstate Medical Center, Syracuse, N. Y.

[1] Mental hospitalization practices in some other countries differ radically from our own. However, no attempt at a comparative study of this subject will be made here.

iceman-patient; 4. Prison hospital—prisoner-patient.

There are similarities as well as differences among the four types of medical hospitals. Since the patients in all four groups are physically (bodily) ill, all of the hospitals belong to the superordinate class, usually called simply "hospital." The differences among the hospitals are *social*. In other words, if a person is sick, the criterion which determines whether he belongs in one or another patient-group is social, *not medical*. Eligibility for patient status in private and public hospitals depends on the ability to pay. To be a patient in a military or prison hospital, on the other hand—assuming that one is sick—it is necessary to be a serviceman (or his dependent) or a prisoner.

These four categories are offered as models for organizing our ideas concerning currently existing hospital practices. VA hospitals, or hospitals operated by companies for their employees, or by labor unions for their members, do not exactly fit into any of the four groups. They may exhibit characteristics of one or several of them.

The patient's freedom and self-determination with respect to his health care—and specifically with respect to his movement into and out of the hospital—is greatest in the first group and decreases progressively toward the fourth group. Thus, gaining admission to and leaving a hospital is largely in the hands of private patients of means. It is much less in the hands of charity patients; still less in the hands of military patients; [2] and, finally, prisoners have no direct control over their movement between prison and prison-hospital. Parallel with the decrease in the patient's control over his movement into and out of the hospital, there is a similar diminution of his power as opposed to the power of the hospital authorities. The private hospital-paying patient model approaches most closely a situation of equality or mutuality between the parties. According to this arrangement, hospital and patient enter into a contractual agreement; each consents to do certain things, and to eschew others. Neither can be coerced, at least not easily, to act against his self-interests (as defined by each for himself). Thus, patients need to undergo only treatments they elect, and they are free to leave the hospital whenever they choose. Moving from the first toward the fourth model we traverse a path characterized by progressive loss of the patient's power vis-à-vis the hospital authorities. The hospital thus acquires increasing control over (some aspects of) the patient's health care. This is one of the reasons why the traditional teaching hospital, if it was a municipal "charity" hospital (which was usually the case), provided so false a model of patient-care for those physicians whose subsequent task was to care for middle and upper-class patients. The "slave-patient," whom the physician can control in the manner of a "benevolent tyrant" and who does not "interefere" by asserting his own needs and ideas, often becomes the "ideal patient" in the eyes of the medical student. He may remain this ideal to some physicians for the rest of their lives.

[2] This description is valid only for servicemen of relatively low rank: say, enlisted men generally, as contrasted with officers. So-called VIPs (Very Important Persons) often seek medical care in military hospitals. In their case the reverse kind of hospital-patient relationship prevails. That is to say, VIPs have *more power* over military hospitals (and their employees, including the physicians) than over private medical hospitals. Probably partly for this reason they often prefer military to private medical institutions.

THE MENTAL HOSPITAL

Although the social structure of the mental hospital has been intensely studied in recent

years (1, 10), many problems concerning its precise human make-up, legal status and psycho-social function remain to be elucidated. Schwartz and Schwartz (9), commenting on the various models applicable to the management of mental hospitals, noted: "Although the stated goals may be to treat patients and to help them to return to society, a mental institution usually has other goals such as protecting society against deviants, protecting patients against themselves and each other and caring for certain persons unable to care for themselves," (p. 436). I have suggested elsewhere (15) that the primary purpose of commitment is social restraint of the offending individual rather than his "treatment" (in the usual sense of this word).

The similarities between medical and mental hospitals are largely verbal or definitional. In other words, in both instances we refer to buildings officially designated as "hospitals." Both types of hospitals cater to persons called "patients," and are staffed by professional workers called "physicians," "nurses," etc. Both are devoted to the diagnosis and treatment of (so-called) "diseases." Finally, both may be supported privately, publicly, or by a combination of private and public funds. In sum, the similarities between medical and mental hospitals are *institutional* rather than *instrumental*. This is consistent with the observations that the similarities between medical (and surgical) treatments and psychotherapy are also largely institutional (16). In this connection, it is significant that many general (medical) hospitals nowadays contain psychiatric units. In these instances, the similarities between the two types of institutions are maximized. As a result, many persons tend to lose sight of the crucial differences that remain between medical and mental hospital practices (18, 19).

Private as well as public mental hospitals must be licensed by appropriate state boards. In this they do not, of course, differ from other hospitals or, for that matter, from restaurants, liquor shops, etc. The two differ in that *each is licensed to do very different things!* For the sake of precision and concreteness, in what follows I shall consider the situation as it exists in New York State (11–13), since currently I am most familiar with it. Similar regulations govern psychiatric hospital operations in most of the United States (3, 4, 6, 7, 8).

What, then, are medical and mental hospitals licensed to do? Medical hospitals are licensed to provide medical and surgical treatments and diagnostic procedures for patients. These must be carried out within the confines of the hospital and under the technical supervision of its professional staff. Thus, the hospital has obligations and responsibilities to three different groups: the patients, the hospital staff and the state (as representative of the interests of the general public). I should like to emphasize here a basic feature common to all medical hospitals: namely, that they are authorized to care for only those patients who voluntarily consent to hospitalization and treatment. The use of diagnostic or treatment measures without the patient's consent constitutes "assault and battery" and is a criminal offense. Only in serious emergencies, or if the patient is unconscious or a minor, may hospitals and physicians deviate from this rule. In these circumstances, near-relatives assume the role and authority of granting or withholding permission for medico-surgical procedures. There are a few exceptions to this rule, the involuntary restraint and treatment of patients with tuberculosis or leprosy being most typical. The subject of involuntary treatment as a public health measure raises many difficult ethical and legal questions which will not be examined

here. Although hedged in by some exceptions, self-responsible, voluntary treatment is clearly the ideal goal toward which democratic patterns of health-care strive.

Thus, except for prison hospitals, medical hospitals are legally empowered to care only for voluntary patients. In sharp contrast, mental hospitals of all types are licensed, among other things, to hold and "treat" patients against their will. Of course, this is hardly new information for psychiatrists or indeed for anyone acquainted with the subject. It is emphasized simply to underscore what I consider to be one of the crucial differences between medical and mental hospitals and their relationships to their respective patients. Let us make explicit precisely what "hold" mental hospitals have over their patients.

COMMITMENT AND VOLUNTARY ADMISSION

Most states recognize two methods of entering a mental hospital: commitment and voluntary admission. Commitment establishes a relationship between hospital and patient unlike anything encountered among the existing four medical models of hospital-patient relationship. *The committed mental patient's relationship to the hospital must frankly be recognized as much more similar to the relationship of prisoner to prison authorities than to anything in the medical scheme of things.* (Whether this is "good" or "bad" is another matter which will not be considered here. To deal with this problem, however, it is necessary first to agree on the goals of psychiatric treatment, both generally and for any particular patient.)

So-called voluntary admission is a relatively recent development in the history of mental hospital management and has not received the attention which it deserves. Its use is steadily increasing, for it is advanced as alleged proof of the similarities between medical and mental diseases. An examination of the precise nature of what actually is meant by "voluntary admission" to a mental hospital will, however, reveal once more the significant differences between it and a regular medical hospital admission.

Guttmacher and Weihofen are representative of those who advocate voluntary admission laws. They wrote:

> "Whereas commitment connotes a legal command by which a person is placed in an institution, voluntary admission signalizes recognition of the new conception of 'insanity' as a form of illness calling for medical care. Such a conception was, of course, impossible so long as commitment was resorted to only as a means of confining the dangerous insane. But after the view became accepted, legally as well as medically, that commitment might be proper, not only where it was necessary for the safety of the public or of the patient, but also where it might be conducive to his restoration of health, it was inevitable that we should come to regard mental illness as not essentially different from physical illness, and to believe that a person able to realize that he is mentally ill should be able to obtain hospital treatment as easily and as informally as he can for physical illness" (4, pp. 305–6).

The logic of this argument is astonishing, for what is being asserted is that by treating A and B similarly, we shall uncover and establish certain similarities between A and B (in addition, that is, to having treated them alike). To put it differently, whether so-called mental disease is similar to physical disease, and if so, in precisely what ways, would seem to me to be a task for empirical research and epistemological analysis. But instead of undertaking either of these tasks, the authors (and many others) advocate *social action* as a means for establishing empirical facts and logical constructs (18, 19).

In addition to this peculiar—and, it seems to me, completely false—reasoning, Guttmacher and Weihofen advocated certain measures which Wertham considered typical of the operations of (what he called) the "psychoauthoritarian" psychiatrist (21). Specifically, after considering voluntary admission laws, Guttmacher and Weihofen proceeded to "welsh," as it were, on the contract between mental hospital and patient. Having argued that mental hospitalization should be as similar as possible to medical hospitalization—since, in their words, "mental illness [is] not essentially different from physical illness," (4, p. 306)—they turned around and argued against the mental patient's freedom to leave the hospital at will. Their position is widely shared by psychiatrists and once more may be considered representative of forensic psychiatric opinion generally (2, 6).

> "With regard to provisions for release," wrote Guttmacher and Weihofen, "two opposing considerations must be weighed. On the one hand, complete freedom to leave the hospital at any time will almost certainly lead a number of patients to leave a few days after being admitted, for restlessness and dissatisfaction with the restraints of hospitalization are common and natural especially during the first period of adjustment. This makes the admission a complete waste of time and money. On the other hand, refusal to release a voluntary patient on demand would not only be difficult to justify legally but would be highly undesirable because resort to voluntary admission will be discouraged unless it is made quite clear that a patient may change his mind and leave. Most voluntary admission statutes meet the problem by providing that a voluntary patient shall be released within a specified number of days after he gives written notice of his desire to leave *unless, in the meanwhile, the hospital authorities start proceedings to have his status changed to that of involuntary patient.* It has been held that detention for a reasonable number of days after written demand for release is proper, although a refusal to release without legal proceedings being taken is illegal and may be ground for claiming damages for false imprisonment.
>
> New York has added another sanction to prevent premature demands for release by requiring an applicant for admission to sign an agreement that he will not give notice for at least 60 days. If a patient nevertheless demands release before that time, it seems dubious whether this provision would justify holding him, although it presumably would at least in theory subject him to liability for damages for breach of contract. The written agreement, however, no doubt has moral if not legal effect in postponing demands for release," (italics added; 4, p. 307).

What Guttmacher and Weihofen and others subscribing to such procedures advocate amounts to nothing less, in my opinion, than luring the patient into the hospital with false promises. If voluntary hospitalization were *really voluntary,* the mental patient would be free to enter *and* leave the mental hospital in the same manner as he enters and leaves a medical hospital. But this is not the case. *Voluntary admission is rather like voluntary commitment.* Or, to put it another way, the voluntary mental patient's role is a cross between the roles of prisoner and medical patient; such a patient is half-committed and hence a prisoner and half-free and hence a regular patient.

The relationship between mental hospitals and mental patients may be further clarified by focusing on some of the *privileges* which public mental hospitals (i.e., state hospitals) and so-called hospitals for the criminally insane (or insane criminals) have vis-à-vis their inmates (11, 12). It is well-known that committed patients—and to lesser extent, even voluntarily admitted patients—lose some of their (civil) liberties

upon entering a public mental hospital (14). Another significant difference between medical and mental hospitals lies in the physician-patient ratios of the two types of institutions. The physician-patient ratio is relatively high in medical facilities; in psychiatric facilities it is often exceedingly low. For instance, a mere handful of doctors, perhaps less than a half-dozen, might constitute the medical staff of a state hospital caring for thousands of patients. On the basis of such facts it might be better argued that these hospitals are only nominally medical institutions, rather than that they are (or ought to be) like other medical institutions, characterized by high physician-patient ratios (6, 22).

Hospitals for the Criminally Insane

Hospitals for the criminally insane constitute a type of psychiatric facility the medical characteristics of which, instrumentally defined, are practically nil. They, too, have an infinitesimally small physician-patient ratio. But even if this ratio were raised (and whether this would do much "good" is again another question), the fact would remain that such so-called hospitals are merely thinly disguised prisons. Indeed, these "hospitals," commonly called "maximum security institutions," are much more strictly guarded and restricted than most prisons. Finally, in the state of New York, "hospitals" for the criminally insane are under the legal jurisdiction of the Department of Corrections. They thus differ from state hospitals, which are under the jurisdiction of the Department of Mental Hygiene.

The following is the legal definition of the functions of the two "hospitals" for the criminally insane in New York State: The Dannemora State Hospital is "for male convicts declared mentally ill while serving a sentence for a felony, or certified mentally ill defectives serving a sentence for a misdemeanor or other offenses," (13, p. 104). The Matteawan State Hospital is "for the mentally ill committed by order of courts of criminal jurisdiction and for male persons convicted of petty crimes or misdemeanors—not felons—or female persons from any correctional institution becoming mentally ill while undergoing sentences; also patients in other state hospitals who were previously convicted or confined in Matteawan State Hospital and still exhibit criminal tendencies or who are adjudged 'dangerously insane,'" (13, p. 105). Accordingly, it would seem more accurate to call these institutions "prison hospitals" rather than "state hospitals." This inference is further supported by the laws pertaining to them. For example, it is stated:

> "The *commissioner of correction* shall make bylaws and rules and regulations for the government of the hospital and the management of its affairs. . . . The *commissioner of correction* shall, whenever there is a vacancy, appoint a superintendent for the Dannemora State Hospital, who shall be in the competitive class of the civil service and be a well-educated *physician* and a graduate of an incorporated *medical college* of at least five years' actual experience in a *hospital* for the care and treatment of the insane" (italics added; 11, p. 151).

Similar regulations apply to the Matteawan State Hospital (11, pp. 157–158).

I submit, therefore, that these two hospitals for the criminally insane (and others similarly regulated) are, in fact, parts of the state's prison system. They are *special prisons*, prisons for the "criminally insane," if one wishes to so designate their inmates, but they are prisons, in every sense of that word. It would seem salutary for the psychiatric and medical profession, as well

as for the general public, to frankly recognize this fact.[3]

THE MENTAL HOSPITAL SUPERINTENDENT VERSUS THE PATIENT

The history of mental hospital psychiatry, especially in the United States, is littered with the carcasses of legal battles between patients and hospital superintendents. This type of litigation, having the form "John Doe (patient) v. John Smith (superintendent)" is instituted whenever a committed mental patient seeks release against the wishes of the hospital authorities. The patient's only recourse in this situation is to bring suit against the superintendent, requesting that due cause be shown to justify his detention. We shall not be concerned here with how these suits are adjudicated legally, nor with the psychiatric reasonings usually advanced to justify holding the patient in the hospital against his will. These and other aspects of this typical medico-legal dilemma will be examined in detail elsewhere (17). For our present purposes it will suffice to concentrate on the social and legal aspects of this phenomenon and to raise some questions.

The problem which we must elucidate is simply this: John Doe (mental patient) wishes to be released from the hospital; John Smith (the superintendent of the hospital) does not wish to let him go. The following questions must be asked and answered: Why does the patient wish to leave? Why does the superintendent not permit him to leave? Who is in control of the patient's movements and freedom in this situation? If the patient is actually being deprived of a measure of self-control, how is he to *gain* the self-control necessary for socialized living?

This dilemma—and the actual forms of the lawsuit—make one thing inescapably clear: namely, that patient and hospital (represented by the superintendent) are now squarely in opposition to one another. In such a case, the psychiatrist can no longer be said to be a representative of the patient. The two are not on the "same side" or on the "same team." On the contrary, they are adversaries! Yet, the fact that involuntarily hospitalized mental patients may sue their physicians but *cannot fire them* shows how little the adversary character of this relationship is officially recognized (14). Irrespective of what the patient might wish or do, so long as he remains in the (state) hospital, the hospital-physicians remain his "personal doctors." This is almost as though the plaintiff to a suit was forced to rely on the defendant's attorney for the prosecution of his claim! My point is that the patient versus psychiatrist lawsuit gives judicial embodiment to the basic thesis of this essay: namely, the documentation of the significant differences between the relationships of medical and mental patients to their respective hospitals. Mental hospital patients (especially those in state hospitals) could thus be said to be *captive patients*.[4]

[3] It would be tempting to draw an analogy between the mislabeling of hospitals on the one hand and the mislabeling of foods or drugs on the other. A parallel might also be drawn between the mislabeling of hospitals and the chicanery connected with the television quiz shows that have recently been investigated. I shall resist this temptation and shall do no more than call the interested reader's attention to these analogies.

[4] Presumably there is no need to belabor the well-known historical fact that mental hospitals used to be prisons. Because of numerous semantic, and a few social, changes in mental hospital practices during recent decades, many contemporary psychiatrists apparently have convinced themselves—as well as their audiences—that the prisoner status of mental patients is entirely a thing of the past (6). The purpose of this essay was, in part, to demonstrate the similarities between the roles of mental hospital patient and prisoner that still remain.

—on the analogy of captive audiences—to a degree unimaginable (in a democracy) in medical practice.

SUMMARY AND CONCLUSIONS

The purpose of this essay was to clarify the precise nature of the relationship between *mental* hospitals and patients and to compare and contrast it with the relationship between *medical* hospitals and patients.

Four types of medical hospitals, offered as general models, were described. These are: the private, the public, the military and the prison hospital. The differences among these are economic, social and legal rather than medical. The hospital-patient relationship is the most equalitarian in the first type of institution and becomes progressively more oppressive for the patient as he moves toward the fourth type.

The similarities and differences between medical and mental hospitals were briefly reviewed. The most significant difference between the two is that mental hospitals are empowered by law to hold and "treat" patients against their will whereas medical hospitals are empowered to care only for voluntary patients. Large public mental hospitals are especially unlike medical institutions in many other characteristics as well (e.g., very low physician-patient ratios, widespread violation of the confidentiality of the patient's communications, etc.) Lastly, certain so-called mental hospitals—that is, those for the criminally insane—were shown to be integral parts of the state's prison (correctional) system.

The mental patient's lawsuit against the hospital superintendent was examined for the light it throws on the antagonistic rather than the co-operative relationship which often exists between these two parties. There is no parallel to this anomaly either in medicine or law. In the former, the patient has no need to sue his physician merely to escape from his control. When he does sue him, the physician is, *ipso facto*, no longer the patient's "personal doctor." In jurisprudence, the litigants are *defined* as adversaries. It would be considered absurd if a plaintiff were to rely on the defendant's attorney for the prosecution of his claim. Yet precisely this absurdity is often forced on the involuntarily hospitalized mental patient.

In view of these considerations, reappraisal of the medical and psychiatric aspects of these institutions seems to be in order. The claim that mental institutions are like medical hospitals must be rejected. The advisability of the continued operation of these institutions along medical or quasi-medical lines should be subjected to serious re-examination. Perhaps they may be better operated along explicitly socio-psychological lines—for example, by psychologists, sociologists, social workers, etc. Finally, the legal status of mental patients must be clarified and more explicitly defined.

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DELL LEBO, PH.D.

Mental health and occupation in the Rorschach analysis of an Egyptologist

Much of the behavior and many of the activities of man enable him to seek status and a good self-concept. Even one's work frequently fulfills needs of which one is unaware. A good illustration of the close relation between personality and career was obtained recently when, in private practice, the writer psychologically examined a male college graduate for an insurance firm. The subject's behavior during testing and his many Rorschach responses clearly revealed the close connection between his former employment, status seeking, self-concept and emotional adjustment. This young man had decided to abandon his profession to enjoy the financial benefits of our expanding economy as an insurance salesman.

His intelligence was superior to that of 98 per cent of the general population. In addition, he thought creatively, saw original aspects of commonplace situations and dealt effectively with abstract concepts. His motivation to succeed in his new job was strong enough that he could enjoy some of the deference he willingly accorded to those of higher status who, in his eyes, received greater monetary rewards than those to which he had been accustomed.

Indeed, his interest in people revolved around status and position, not in the give and take of emotional interaction with them. Because of his feelings of inferiority he was extremely sensitive, seeing threat

Dr. Lebo is Clinical Psychologist at the Duval County, Child Guidance and Speech Correction Clinic, Jacksonville, Fla. He is also a Lecturer in Psychology at Jacksonville University and a consultant to the Educational Services Institute and to the Juvenile Court. This article was adapted from the fourth of a series of talks in the discussion leaders training program conducted in 1960 by the Mental Health Association of Duval County. Many of the attributes of mental health were developed from those considered by C. C. Steckle in *Problems of Human Adjustment* (New York: Harper and Brothers, 1949).

and rejection where none actually existed. He felt that people were inclined to reject him.

He used two principal methods to overcome his anticipated rejection by others: (a) by assuming readily and willingly a subservience to those regarded as superior to him—those higher in the power hierarchy—so that they would like him (indeed, his employer was much impressed with this chap, possibly, in part, for that reason); (b) by rejecting figuratively, but immediately, those he considered "beneath him." Because of his inner depreciation of his own worth, he sought to enhance his self-esteem by despising mankind in general. As a result of such emotional difficulties, he preferred to keep people at a distance, to deal with them but without personal involvement, to manipulate rather than to understand them.

Signs of such rejection and simultaneous assertion of superiority were apparent in an elaborate facade of actions during the psychodiagnostic session—his nonchalance (as evidence by slouching in the chair until a knee rested on the edge of the desk), staring the examiner in the eye and, best of all, an elaborate ritual of knuckle cracking which involved clasping his hands and extending his arms full length and turning his palms outward. This last action was interpreted symbolically as keeping the examiner at a distance, if not as pushing him away. On the other side of this facade was a complaisance bordering on the obsequious. As the examination proceeded the false front broke and he began to chain smoke cigarettes and to swallow repeatedly and noisily. Such actions suggested a need to find, in familiar activity, relief from threat and a dry mouth, such as that produced by tension. His approach to the Rorschach plates altered too. What had been original responses became bizarre free associations.

Such indications suggested that under real or imagined pressure from the environment his already weakened ego would collapse and he would flee into fantasy or into serious regression.

His training and his profession? Egyptology, a science concerned with the remains of a past human life. He had worked as the curator of a small museum before considering insurance selling. While his past professional training and experience seemed ideal for his personality make-up, selling insurance would probably prove too threatening to him, involving, as it often does, sales made on the basis of close interpersonal relations, a dominant yet friendly approach, and considerable competition.

Such threats might well increase the unstable aspects of his character and make his mental health so poor as to drive him into neurosis or psychosis, according to his protocols. In view of these findings it was recommended that he not continue his training in the insurance program.

TEN ATTRIBUTES OF MENTAL HEALTH

Being easily disturbed by threatening circumstances is one of the signs of poor mental health. A mentally healthy person is able to

1. *Face and overcome obstacles* without being permanently upset. Aspects of life occasionally threaten many of us. We can hardly avoid serious mistakes, failure, unanticipated expenses and change. All may cause a momentary discouragement, heightening of tension or even a depressive reaction. But the effect is not lasting. The person with good mental health is resilient. He is soon working realistically to overcome environmental frustration or setback.

Another sign of poor mental health in the chap desiring financial success in insurance was a conflict between his desires and his capabilities. A mentally healthy person is able to

2. *Match desires with reality* and not allow wishes for the unobtainable to disrupt his present performance. He does not devote himself to complaining about the inevitable, blaming fate, cursing enemies or wishing things were different. Motivation, like wishes, is not enough. No matter how much one may want to succeed, unless he has the qualifications, failure and chronic disappointment are likely in the pursuit of unrealistic goals.

The former Egyptologist's belittling regard of most people is also a sign of a poorly adjusted personality. A mentally healthy person is

3. *Congenial.* While he is aware of the faults some others may have, he views people generally as amiable and helpful. He enjoys associating and working with his fellow humans and can sympathize with their distresses and enjoy their successes. One of the best signs of good mental health is being welcomed into the company of others.

The Rorschach test had revealed that the respondent was too much concerned with status and position. In fact, such concern may have led him into the relatively little known and uncrowded field of Egyptology where competition presumably would be less than that expected in the insurance business. In his present concern for some of the tangible symbols of success, the young man had stifled thoughts about his debt to society.

The mentally healthy person

4. *Recognizes a debt to society.* He realizes that he has social as well as personal obligations. Just as the rules of society (law and custom) offer protection for the individual, so too do they extract conformance from the individual. A mentally healthy person does not constantly rebel against such payment. He also believes that the world is progressing, that it is now a better place than it was previously. There is another obligation here. He recognizes that he too must in some way help make the world a better place than it was when he entered it. Realistically he recognizes that his contributions may never be grand or become known. But the knowing of them within himself is sufficient. Deeds in discharge of the debt to society help promote mental health.

The sudden abandonment of a career—which is quite compatible with an individual's personality—for another and incompatible career is a form of inconsistent behavior. Inconsistency, in any one of a number of forms, is usually a sign of poor mental health. The mentally healthy person is

5. *Reliable* in his behavior and in his emotional state. He is consistent and so can be counted upon by others because his present actions are governed by reason instead of impulse, whim or emotion. This statement is not meant to imply that the mentally healthy person is unemotional. Indeed not. He does express his emotions. He laughs or cries as the situation demands. But his emotions are responsive to the situation and not to inner needs.

Although he is consistent, the mentally healthy person is not rigid. Instead he may be called

6. *Adaptable.* He realizes that when a disturbing situation cannot be changed, he himself can change. Such changes take place constantly in adjusting to the demands of military living, graduate study and the corporate structure. With few exceptions, anyone who cannot be changed, no matter what the circumstances demand,

is poorly adjusted. Frequently, however, it is easier to change the situation.

Good mental health does not imply instant obedience or servile compliance. It implies a willingness to examine the possibilities of change in oneself.

The fact that the young man tested was able to look upon the world in unique ways, until threat and emotional difficulty caused him to make poorly adjusted responses, suggests that he did have adaptive qualities in addition to many other psychological strengths. Some of his aspects of good mental health included

7. *Productivity.* The many well-organized things he saw in each Rorschach plate suggested that he was capable of similar productivity on the job provided anxiety and frustration did not occur. Like amiability, some writers consider productivity —doing a good day's work—to be one of the best signs of mental health, because a frequent neurotic response is the abandonment of tasks when they become too threatening. Such responses are epitomized in the semihumorous saying "I should have stood in bed." It was anticipated that the testee's productivity would soon dwindle if he accepted the (threatening) position he (thought) he wanted.

Another sign of strength in the testee was an awareness of the importance of the past as well as the present and the future. While he seemingly was attempting to divorce himself from past ties and interests and was looking almost exclusively towards future financial success, he actually had good

8. *Time orientation,* which enabled him to work in the present while planning for the future. Nor, as later counseling revealed, was he without knowledge of how his past had contributed to his present situation and how both might contribute to his future. He could distinguish between planning and wishing and between planning and worrying.

Aspects of his former life which had enabled him to secure his bachelor's degree (while raising a family and working) were present. Thus he was

9. *Self-reliant.* When confronted with the facts he could decide without undue hesitation or vacillation.

Perhaps the most fortunate of all the characteristics of good mental health that he possessed was his willingness to be psychologically examined.

At first his employer decided to continue with the young man in view of his intelligence, high motivation and the money that had already been expended in a training program of several weeks. However, after discussing the report with its subject, the employer changed his mind and sent his trainee for counseling. During this session, the mentally healthy features of his personality enabled a realization of the threats a life of an insurance salesman would impose. He saw that it was not for him. In fact, he indicated that he had already felt some serious doubts about his new choice of a career. He was thankful to be fully acquainted, after a relatively short period of time, with many things of which he already had an inkling. His

10. *Willingness to be appraised* was a healthy sign because he, like any person with good mental health, realized that ambitions must be brought in line with attitudes—as well as aptitudes—in order to experience pleasure in success. The mentally healthy person is not afraid of medical examinations, dental inspections, psychological tests or psychiatric interviews. He is not so fearful of what the tests may reveal that he avoids them. Instead he knows that they can contribute toward good health. If his—or his parents'—plans for

the future demand more than the past justifies or present activities indicate, he changes his plans. He seeks an occupation where his interests are compatible with his efforts and where equivalent satisfaction may be obtained. The young man, for example, might satisfactorily substitute scientific prestige for financial status or he might endeavor to receive—through research grants and field trips—what he sought in commissions and company sponsored vacations.

Fortunately he will not experience the chronic unhappiness of a frustrated career that many individuals suffer because they were not amenable to appraisal of their intellectual and psychological capacities. Such individuals are often victims of a popular delusion that one can be whatever he desires if one really wants and tries hard enough. The requirements and demands of many positions are known and clearly established. There are tested and proved methods for learning how well a person meets the requirements and can face the demands. Today it seems a matter of poor planning, and poor mental health as well, to embark upon a career without consideration of one's abilities and personality when such knowledge can be obtained easily.

NORMAL PERSON VERSUS GREAT PERSON

The man who took the psychological examination was real. The signs of mental health, although they were related to him, are largely hypothetical. Humans and their interactions are so complex that it is easier to see poor mental health than it is to define good adjustment. That is the reason there are shelves of books on abnormal psychology but few writings on normal psychology. That is the reason most courses in mental hygiene deal prominently with neurotic and poorly adjusted behavior. Also, the abnormal is more flamboyant and it attracts our attention, but an individual possessing all of the features of good mental health would not stand out from the crowd and so might seem likable but uninteresting. It is the eccentric, the novel, the unexpected that adds zest and sparkle to human relations.

Nor may the ideally normal person be the great person. George Washington, for example, was by no means normal but he was great. He did not achieve his lasting popularity by following every popular cause.

> "Washington lacked many of the attributes of some heads of chambers of commerce and multi-echelon organizations. The one thing he never lacked, even when he was in error or defeat, was *integrity*. . . . Washington never looked back to see just who was behind him or which way opportunism pointed. That is why he became father of his country" (1).

Similarly, many of Gurko's (2) descriptions of the antagonism between society and inventors, artists, and scientists would seem to indicate that such people, if possessed of potential greatness, do not have the attributes of good mental health.

Most of us cannot be great persons. We can, however, all aspire to good adjustment. The attributes of good mental health may be viewed as goals. Even though we may never expect to attain them all equally, or possess them all simultaneously, we may strive to approach them continuously.

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ØRNULV ØDEGARD, M.D.

Pattern of discharge and readmission in psychiatric hospitals in Norway, 1926 to 1955

The evaluation of therapeutic results appears to be even more controversial in psychiatry than in other branches of medicine. The disagreement is still more than lively on insulin coma therapy, a well-defined method which has been widely used for 25 years. One can hardly hope that this is so because psychiatrists are particularly critical but one can at least point out some excuses.

The assessment of patient's clinical condition is difficult in psychiatry. Prognosis depends upon a great number of variables, and therefore statistically significant conclusions can not be reached unless vast material has been collected. Furthermore the problem of "spontaneous" versus treatment-induced recoveries is particularly difficult because treatment and aftercare takes such a long time. In any case *objective* criteria are urgently needed or, more modestly, criteria which are less subjective. In mass statistics two such criteria exist: duration of hospital stay and frequency of readmission. Both are objective in the sense that they can be registered without any subjective interpretation. Systematic errors are not excluded, however. It is probable, for instance, that such factors as overcrowding within the hospital system or unemployment on the labour market influence the discharge pattern. Even a certain bias is possible; therapeutical enthusiasm may lead to a more optimistic discharge policy, but here the readmission figures should make a correction possible.

In a previous paper a comparison was made between the first admissions to psychiatric hospitals in Norway during two 10-year periods, 1926–35 and 1936–45. The results of treatment *as judged by the hospitals* could be shown to have improved significantly, and the assumption seemed to be justified that this could have something to do with the most important difference between these two decades—the introduction (around 1936) of the modern shock therapies.

In the present paper the same material has been followed (by means of the national registration of psychiatric patients) until

Dr. Ødegård is Medical Superintendent at Gaustad Mental Hospital in Oslo, Norway, and Professor of Psychiatry at the University of Oslo.

the end of 1955, which gives a minimum observation period of 10 years following first admission.

For the first decade the follow-up data were used only until the end of 1945 so as to make the two decades comparable with regard to period of observation. The duration of hospital stay is registered in completed whole years from the exact date of admission. Discharge is, in Norwegian psychiatric hospitals, always final, with a maximal trial period of four weeks. Readmission is defined as a new admission to any psychiatric hospital in the country within 12 months. Patients readmitted less than 12 months after discharge are not counted as discharged at all, so as to eliminate the confusion caused by cases who go in and out of hospital at short intervals.

Table 1 gives the probabilities of release,

TABLE 1

A. Probability of being discharged alive and of dying in hospital during successive years of hospital stay per 1000 patients present at the beginning of the year

B. Per thousand distribution of patients discharged alive.

	A				B	
	First admissions 1926–35: 14,337 Within Dec. 31, 1945:		*First admissions 1936–45: 16,038 Within Dec. 31, 1955:*		*Per thousand distribution of patients discharged alive*	
Years in hospital	*Discharged alive per 1000*	*Died per 1000*	*Discharged alive per 1000*	*Died per 1000*	*1926–35*	*1936–45*
0–1	366	78	570	76	447	664
1–2	257	45	239	48	175	99
2–3	137	42	145	44	65	42
3–4	100	38	103	35	39	25
4–5	83	32	83	34	28	17
5–6	73	26	77	32	21	14
6–7	62	26	52	29	17	9
7–8	57	17	48	24	14	7
8–9	49	25	44	26	11	6
9–10	44	22	46	13	9	6
10–12	41	23	36	17	15	8
12–14	33	27	35	14	9	6
14–16	31	26	31	13	6	4
16–18	25	19	25	11	3	2
18–20	27	17	23	13	1	1
				Discharged alive	861	910
				Still in hospital	139	90
					1,000	1,000

TABLE 2

Died in hospital per 1000 present at the beginning of each hospital year

	First admissions 1926–35						*First admissions 1936–45*					
	1	*2*	*3*	*4*	*5*	*6–10*	*1*	*2*	*3*	*4*	*5*	*6–10*
Schizophrenia	32	30	25	27	27	17	25	21	19	21	21	15
Manic-depression	57	48	49	42	50	32	36	28	64	45	40	19
Other functional psychoses	37	23	24	22	19	23	21	18	20	27	21	21
Senile and arteriosclerotic	305	175	184	137	149	87	295	180	180	128	136	134
Other organic (incl. G.P.)	176	110	130	100	117	50	203	193	150	105	120	59
With epilepsy and with mental deficiency	44	26	39	36	32	23	49	31	30	26	24	27
Others (mainly symptomatic)	183	52	53	32	39	21	117	45	53	36	44	17
All diagnoses	78	45	42	38	32	22	76	48	44	35	34	25

alive or by death in hospital, during the years following first admission. Clearly the main difference between the two periods lies in the probability of being discharged alive during the first year in hospital (which has increased from 366 per thousand to 570). During all following years the probabilities are very much the same for the two periods.

The death rates are not adjusted for age but are sufficiently accurate for our purpose, which is to show that there has been no great change in mortality (which could be a source of error when the two periods are compared with regard to duration of hospital stay). In both periods we observe the well-known mortality peak during the first hospital year, with a sharp drop during the second year, followed by a more gradual decline.

In Table 2 death rates are given separately for main diagnostic groups, and the figures bring out that there has been, in fact, some decrease in mortality, which was covered up by the pooling of all diagnoses. (An increased number of senile and arteriosclerotic cases has raised the over-all death rate for the second period.) For schizophrenia and manic-depression as well as for the remaining functional psychoses mortality has decreased significantly, particularly during the first hospital year. Most likely this is a result of a more efficient handling of severely acute cases after the introduction of the somatic therapies. No similar decrease is observed for senile and arteriosclerotic psychoses, and for other organic cases mortality has even gone up somewhat. In these groups the decisive step toward a lower mortality was the introduction of sulpha drugs and antibiotics, which did not take place until later. It should be kept in mind that World War II and the German occupation of Norway, which led to increased mortality, influenced the second period more than the first.

In the following tables the discharge pattern is illustrated by the percentage distribution of patients discharged alive over the successive hospital years.

Table 3 shows that out of the first admissions (1926–35) 45 per cent were discharged within the first year in hospital as against 67 per cent for the next 10-year

TABLE 3

Percentage distribution of patients discharged alive according to duration of hospital stay in whole years

		1	*2*	*3–5*	*6–20*	*Still in hospital*	*Total*
Schizophrenia	1926–35	33	16	14	15	22	100
	1936–45	50	12	11	10	17	100
Other functional psychoses	1926–35	60	19	11	5	5	100
	1936–45	80	8	6	3	3	100
Psychoses with epilepsy and	1926–35	38	20	15	11	16	100
with mental deficiency	1936–45	50	12	12	9	17	100
Organic psychoses	1926–35	60	19	12	5	4	100
(Incl. senile)	1936–45	74	10	8	5	3	100
Others, mainly	1926–35	69	15	8	4	4	100
symptomatic psychoses	1936–45	89	5	3	1	2	100
All diagnoses	1926–35	45	17	13	11	14	100
	1936–45	67	10	8	6	9	100

TABLE 4

Percentage distribution of patients discharged alive according to duration of hospital stay and condition on discharge. (Two diagnostic groups are left out because of insufficient number of cases in some of the subgroups)

		1926–35					*1936–45*				
		1	*2*	*3–5*	*6–20*	*Total*	*1*	*2*	*3–5*	*6–20*	*Total*
Schizophrenia	Good	60	26	9	5	100	80	11	6	3	100
	Fair	51	20	16	13	100	53	16	15	16	100
	Poor	34	20	22	24	100	51	15	17	17	100
Other functional psychoses	Good	68	20	8	4	100	86	8	4	2	100
	Fair	70	14	11	5	100	78	8	9	5	100
	Poor	50	24	16	10	100	71	12	11	6	100
Organic psychoses	Good	64	26	9	1	100	84	10	4	2	100
	Fair	75	14	7	4	100	82	8	6	4	100
	Poor	58	20	15	7	100	74	11	10	5	100
All diagnoses	Good	65	22	9	4	100	85	9	5	1	100
	Fair	61	18	12	9	100	68	11	11	10	100
	Poor	42	21	19	18	100	62	13	14	11	100

period. To simplify the tables the material is subdivided into five main diagnostic groups, each of them being comparatively uniform clinically as well as with regard to mortality and discharge pattern. In all groups the percentage of early discharges has increased markedly. This is so even for the organic psychoses, which could signify that changes in discharge policy have been nearly as important as the new therapeutic methods. On the other hand it is common experience that convulsive therapy can bring about remission even in certain organic cases and besides, the change in discharge pattern is decidedly less in the organic group than in any of the others.

Table 4 shows that the duration of hospital stay has decreased regardless of the result of treatment. The percentage of early discharges has increased nearly as much for patients discharged as unimproved as for the more or less recovered cases. This fits in with the experience that the new therapeutic methods have been useful even in chronic cases where no recovery is possible but where, for instance, a short series of convulsive treatments can bring the patient out of certain pathological attitudes and so make discharge possible. On the other hand one might argue that the more rapid discharge even of unimproved patients suggests a more active discharge policy during the second period, regardless of condition and due, for instance, to the increasing overcrowding in Norwegian mental hospitals during these years. The overcrowding in per cent of the number of authorized beds increased from 8 in 1926 to 21 in 1945.

In all diagnostic groups the length of hospital stay has remained most constant in the middle group with "fair" results. No explanation can be offered for this.

TABLE 5

Readmissions per 100 discharged alive according to duration of first hospital stay and according to condition on first discharge

			Duration of hospital stay				*Condition on discharge*		
		Total readmission	*1*	*2*	*3–5*	*6–20*	*Good*	*Fair*	*Poor*
Schizophrenia	1926–35	33	38	34	31	21	41	35	30
	1936–45	39	41	43	41	25	40	38	39
Other functional psychoses	1926–35	22	24	20	22	14	27	17	19
	1936–45	29	28	34	37	19	30	25	28
Psychoses with epilepsy and with mental deficiency	1926–35	34	34	22	33	21	27	32	29
	1936–45	13	34	38	35	23	38	35	31
Organic psychoses	1926–35	13	11	14	20	15	27	11	12
	1936–45	17	16	20	23	16	25	18	15
Others	1926–35	12	9	15	29	18	14	8	9
	1936–45	15	14	22	23	21	15	13	16
All diagnoses	1926–35	26	27	26	28	19	29	25	25
	1936–45	30	29	37	37	22	30	29	30

The number of *readmissions* per 100 discharged alive gives a rough picture of the stability of the therapeutical results. For the entire material the percentage of readmissions increased from 26 during the first period to 30 during the second, an increase of 4 ± 0.6 per cent. This suggests a somewhat decreased stability of results and the obvious question raised here is if this is a result of the shortened treatment period. The statistical data of Tables 5 and 6 do not bear out this hypothesis, however. Clearly the increase in readmissions is most marked in cases with more than 12 months in hospital, while short-time therapy seems to give just as stable results during the second period as during the first.

Condition on discharge is another important factor. The general rule appears to be that in 1926–35 the good results were more stable than the poor ones, while in 1936–45 this difference has largely disappeared. This trend is particularly clear in the schizophrenic group. Schizophrenic patients discharged in good condition after less than 12 months of hospital stay had 49 per cent readmissions in 1926–35 as against 41 per cent in the second period.[1] Good results obtained after short hospital stay were evidently more stable after the introduction of the shock therapies than before. On the other hand schizophrenics discharged in poor condition after more than two years in hospital had 25 per cent readmissions during the first period but 35 per cent during the second.[2] For the other functional psychoses the tendency is the same, as it is less markedly, even for the organic psychoses.

These findings could be explained as resulting from two independent trends:

1. A more efficient therapy for recent cases, bringing better and more stable results as well as in shorter hospital stay.

[1] The exact difference being 8.0 ± 3.03 per cent.

[2] The exact difference being 10.6 ± 2.14 per cent.

TABLE 6

Readmissions per 100 discharged alive according to duration of first hospital stay and condition on first discharge. Two diagnostic groups are left out because of insufficient number of cases in some of the undergroups

Duration of first hospital stay:		*1 year*			*2 years*			*More than 2 years*		
Condition on first discharge:		*Good*	*Fair*	*Poor*	*Good*	*Fair*	*Poor*	*Good*	*Fair*	*Poor*
Schizophrenia	1926–35	49	35	35	32	39	32	21	30	25
	1936–45	41	44	40	41	43	45	32	27	36
Other functional psychoses	1926–35	31	15	20	20	24	19	18	24	17
	1936–45	30	23	26	32	38	37	29	31	34
Organic psychoses	1926–35	29	10	10	22	9	15	20	17	19
	1936–45	26	16	13	24	25	17	13	24	21
All diagnoses	1926–35	33	22	25	24	30	25	20	27	24
	1936–45	30	27	30	33	39	38	27	28	37

2. Increased pressure for the discharge of chronic patients in a more questionable condition, because of the increasing overcrowding of the hospitals.

TABLE 7

Probability of being discharged alive and of dying in hospital during the first 10 years of hospital stay, per 1,000 present at the beginning of the year
The first admissions (1936–40) are followed until the end of 1946 and the first admissions (1946–50) until the end of 1956

	First admissions 1936–40		*First admissions 1946–50*	
	Discharged alive	*Died in hospital*	*Discharged alive*	*Died in hospital*
0–1	556	72	663	51
1–2	264	48	232	37
2–3	173	55	139	42
3–4	132	39	101	38
4–5	107	47	79	27
5–6	113	39	76	25
6–7	80	42	45	18
7–8	72	36	45	20
8–9	45	33	44	19
9–10	48	16	32	18

In order to serve a practical purpose our hospital statistics should preferably be strictly up-to-date but this is not compatible with the need for a reasonably long period of observation. In Table 7 discharge data are given for two five-year periods (1936–40 and 1946–50) followed up until the end of 1946 and 1956 respectively. It seems clear that the change in discharge pattern has continued after 1946 but on a somewhat reduced scale. The probability of being discharged alive after less than one year in hospital has increased from 556 to 663. More notable is the decrease in mortality, evidently because the new drugs and antibiotics have made the treatment of intercurrent infections more efficient. Also, tuberculosis was practically wiped out in our mental hospitals during these years. Readmission statistics are not included in this comparison because the period of observation is too short.

Comparable statistical data from other countries are scarce, but the study by Morton Kramer, *et al.*, of the disposition of first admissions to the Warren State Hospital in Pennsylvania, seems to be well-suited for comparison. The main difference lies in the wide use of extramural care for the insane in Norway, about 50 per cent of the patients being in some kind of family care. Consequently a number of the releases registered in Norway are actually transfers to another type of public care, and most of these patients would, in the Warren hospital, probably remain on the hospital books. At the same time the patients who are transferred to extramural care probably have a comparatively low mortality because patients in poor physical condition will rarely be placed in family care. This will tend to raise mortality rates in the Norwegian mental hospitals.

Table 8 shows that for each of the four first hospital years the probability of release is higher in Norway. The difference is particularly large for senile psychoses, probably because the Norwegian material includes two fairly large psychiatric clinics which act as receiving hospitals and from which many senile cases are distributed to other types of care (such as nursing homes) outside the scope of the statistical system.

The time trend is quite different in the American hospital. The probability of release does not increase much from the

first decade to the second, while the period of 1946–50 has a much higher release rate. In Norway, on the other hand, the change was about the same from the first period to the second as from the second to the third. The tendency toward a more rapid discharge seems to have started a few years later in the Warren hospital, possibly because of a certain delay in the introduction of the shock therapies. Also the influence of World War II may not have been quite the same in the two countries.

Mortality is generally much higher in the American hospital, particularly during the first year in hospital. The high mortality in senile patients in the Warren hospital is clearly one of the reasons for the lower probability of being discharged alive. It seems quite clear that the selection of patients for hospital admission must be a different one and must lead to a larger proportion of poor risks.

This tentative and inadequate analysis is given merely to show that international comparisons are possible, provided the statistical methods are given, such as in this American monograph. Such comparisons may be fruitful if it is possible to make a careful study of the medical and administrative conditions in the two hospital systems to be compared. Direct comparisons, disregarding possible sources of error, are apt to be grossly misleading.

TABLE 8

First admissions to the Warren State Hospital and to the psychiatric hospitals in Norway. Probability of being discharged alive and of dying in hospital during the first four years, per 1000 of those present in the hospital at the beginning of the year

		Years in hospital	All mental diseases			Functional psychoses			Senile psychoses		
			1926–35	1936–45	1946–50	1926–35	1936–45	1946–50	1926–35	1936–45	1946–50
Discharged alive per 1,000	Warren State Hospital	1	459	457	539	418	481	617	130	115	143
		2	152	168	165	168	216	242	41	31	73
		3	82	81	64	89	97	96	33	14	15
		4	50	56	...	50	61	...	26	7	...
	Norway	1	366	570	663	363	566	690	330	376	364
		2	257	239	232	251	241	263	253	181	150
		3	137	145	139	136	144	133	129	116	99
		4	100	103	...	95	102	...	131	115	...
Died in hospital per 1,000	Warren State Hospital	1	177	213	186	49	83	38	500	578	529
		2	117	96	99	25	32	23	336	300	218
		3	79	102	112	17	36	11	194	302	287
		4	64	65	...	19	16	...	129	262	...
	Norway	1	78	76	51	37	23	17	305	295	255
		2	45	48	37	31	20	11	175	180	163
		3	42	44	42	27	19	16	184	180	155
		4	38	35	...	27	22	...	137	128	...

SUMMARY

A cohort study has been made of all first admissions to psychiatric hospitals in Norway, 1936–45. These 16,038 patients have been followed until the end of 1955, and duration of hospital stay as well as frequency of readmission has been examined in detail. The figures have been compared with similar figures for the 14,337 first admissions 1926–35, followed until the end of 1945.

The probability of being discharged within 12 months increased from 366 during the first decade to 570 during the second. The increase was considerably greater for schizophrenia than for organic psychoses but was significant for all diagnostic groups. It was independent of the condition of the patients on discharge.

The number of readmissions increased slightly but significantly, which suggests a lower stability of the therapeutic results. This particularly applies to patients discharged as unimproved, whereas the good results seem to be even more stable during the second decade than during the first.

The tentative conclusion is drawn that around 1936, mental hospital therapy became more efficient, resulting in better and more stable results as well as in shorter hospital stay. At the same time increasing overcrowding led to pressure for the discharge of chronic patients, in relatively poor condition, to other forms of care. The greater therapeutic efficiency made it possible for the hospitals to comply with these demands but at the expense of more frequent readmissions.

An attempt is made to compare the statistical data from Norway with corresponding data from an American state hospital. The main difference appears to be that the shortening of hospital stay came somewhat later in the American hospital and that mortality was considerably higher.

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JOHN ARSENIAN, PH.D.

Situational factors contributing to mental illness in the United States: A theoretical summary

This paper will explore situational factors or factors in social living and social arrangement in American society which predispose to mental illness. It is an elaboration and application of some ideas about tough and easy cultures presented in a previous publication.[1]

Stated simply, the essential ideas were that a culture which has ineffective, incongruous and inefficient means of satisfying needs or reducing vital tensions requires people to sustain high levels of psychologic tension and hence may be experienced and described as "tough." Conversely by definition a culture which readily and regularly satisfies needs or provides for reduction of biologically and psychologically induced tensions is "easy."

A principal derivation from this hypothesis was that "tough" cultures would have a high incidence of functional disorder along with other signs of deviation from approved patterns of social living such as (for our culture) crime, drug addiction, suicide and other "out of bounds" behaviors.

In the previous paper a procedure was suggested which allowed for cross-cultural comparisons, looking toward a ranking of societies for their potential for socially induced sickness. Existing cultures could be ordered to a continuum between two hypothetical extremes: a polar tough culture and a polar easy culture.

The present focus on mental illness as a concomitant of the toughness of American culture is made because mental illness is authoritatively considered a large-scale public health problem in this society.

The theoretical assumptions underlying the previous formulations were not new ideas, and this is equally true of the additional ideas incorporated here. Intellectual

Dr. Arsenian is Director of Psychological Research at Boston State Hospital, and Assistant Professor of Clinical Psychology at Boston University, Boston, Mass.

[1] Arsenian, John and Jean M. Arsenian, "Tough and Easy Cultures: A Conceptual Analysis, *Psychiatry*, 11(November, 1948), 377–85.

indebtedness was expressed to a number of anthropologists, sociologists, social psychologists and psychoanalysts.

The clinical material which supports the present formulations will not be summarized here. The material is composed of outlines of the unhappy life experiences of more than 500 adult and adolescent mental patients whose lives have been topically reviewed by interviews directed at understanding the forces antedating and precipitating their mental illness.

The interview material and life history data were recorded from cases collected over a 10-year period. For most of these patients psychological tests were obtained, studied and interpreted prior to staff conferences. Some of these tests were aimed at discerning the patient's current problems and something of personal history disposing toward "breakdown."

By allowing the mind to dwell upon and abstract the common denominators of these combined materials, it was hoped that true relationships could be discerned. The commonplace quality of most of the notions employed and emerging may strengthen the case for their value, reserving the term "validity" for statistical confirmation or verification. The procedure makes use of commonplace assumptions of the disciplines of psychology and psychiatry and sociology. What is said is obvious, yet by integrating obvious statements there emerges a set of consequences which may not seem so obvious. This also applies to a set of remedial steps which recommend themselves as following from the analysis. Particularization of what to do—involving matters of social policy and expediency—is not within the scope of this paper.

BASIC ASSUMPTIONS

Needs, tension, overloading

The following set of assumptions and concepts is required for this analysis of situational factors contributing to mental illness. These will be defined and their operation briefly demonstrated. The first few provide a framework which seems applicable to instances of distressed deviance in cultures generally. The later axioms carry progressively more relevance to problems salient in the U.S.A.

First it is axiomatic that humans have some innate and some socially induced needs which, in some combinations, produce responses directed toward satisfying these needs.

Suppose that to each need is associated a degree of "tension" which, reaching a certain level, prompts action to reduce tension.

Also suppose that there is such a level of tension that a further increment produces *overloading* with: (a) resulting disorganized outer behavior, or (b) a disorganization of the personality or inner psychic organization, i.e., mental derangement, "nervous breakdown," mental illness.

An overloading of increments of tension at barriers sometimes prompts temper tantrums, running amuck, unconsciousness with or without diffuse motor discharge, even death, as from "shock" due to terror or (ironically) tickle. Familiar illustrations of disorganization of perception and personality linked to overloading of tension are the hallucinated mirage of the thirsting man, amnesia for the intolerable, delusions of reference for the guilty. Psychologic processes of perception, speech, memory, reasoning, feeling, etc., may be separately deranged or more general disorganization of personality may follow overloading of tension, as in stupor or mania.

Second assume that *every person has a "breaking point,"* a point beyond which he can tolerate nothing further without explosive outer behavior or inner disrup-

tion or both, and that this is dependent upon two factors: his inheritance and his experience.

Barriers, frustration, stress

For some needs at some times there exist barriers requiring the sustaining of tension. Barriers and restraints are part of the structure and/or habits of a culture.

The term "stress" is here used to describe any regularly repeated or long-continued relation between person and environment, such that tension is or becomes or may become high.

The previous paper, as mentioned, defined a "tough culture" as one which induced and sustained high levels of psychologic tension. By definition the ideas of a tough culture, high levels of tension and stress are being linked. Thus a culture or environment may be more or less stressful and the individual more or less tension loaded or frustrated. Where aroused needs are not integrated with path-goal patterns that enable a person to satisfy needs or reduce tensions, the term "stress" will be used.

Modal culture, modal man

Societies, cultures, nations, social classes may be habituated to more or less similar artifacts, systems of relationships and path-goal patterns. It is thus possible to speak of American, German, French, Papuan culture.

More of an abstraction is the construct of the average or *modal* man for a given culture. To some extent genetic homogeneity and, to a greater extent, the stamp and more or less continuous moulding of each given culture upon its added (infant) members by the socialization process produces a national character.

Because of its mixed peoples in "melting pot" United States the construct of the average American rests more upon uniformities in the education and indoctrination process than it does upon genetic closeness.[2]

Social life cycle, age grading

Birth, growth, reproduction, decline and death express the biological life cycle of man and of many other creatures. Each culture has a *social life cycle* more or less well-defined which runs more or less parallel to the biological cycle. Where the biological cycle is punctuated by the unfolding of certain needs and readiness, as for sex and reproduction, and the habits of the culture are not in tune, the discrepancy defines a stress in the culture linked with a lift in tension. There are culturally stamped habits, rights, expectations, burdens, duties, skills, titles, privileges, etc., which go with age.

Just as Gesell has pieced out the maturation of motor and, to a lesser extent, psychologic development in the child, it would be possible to discern for any given culture a *social* life cycle for the modal person. On the average, at this age one is weaned, cleaned, put to work, sexually initiated, considered adult, etc.

A modal life cycle serially details the things one is expected to do or not do and defines the tensions which one is allowed to reduce or expected to bear.

A culture's tension load requirements may vary for different age groups. For example, it is easier to be a child in the U.S.A. than to be an adolescent, easier in

[2] If there are differences in tension-level-tolerance of various genetically homogeneous stocks, American culture imposes a more difficult burden of conformity and control on some people rather than others. For instance, if biogenetically "Italians" are more volatile than "Englishmen," the same barriers will be experienced as more tension-producing for Italians.

terms of tension loading and possibilities of tension reduction.

TRANSITIONAL SUPPORTS

Rites of passage

Transitions from one group to another, sometimes called initiation rites or rites of passage, are notable events as recognized by lay reference to them as "milestones." Conceptually a rite of passage defines, at once, a *barrier* and a *path*. The ceremony, rite or ordeal marking the transition may be more or less stressful and the immediate terminal, as well as the long-range situation, may involve either an elevation or lowering of the tension level.

Where transition or admission to a new status, position, group, privilege, etc., is guaranteed by age and without a ceremonial ordeal, tension is low or minimal. Where admission is selective and conditional or tied to a stressful initiation rite, more tension is imposed. How much more depends upon the particular ordeal, the needs involved and their place in the hierarchy of values. For example, transition to the class of voters is minimally stressful; the privilege is not uniformly highly valued, hence its age barrier is not associated with much tension, nor is there a ceremonial rite to mark the transition. More tension is involved in the age-limited license to drive an automobile, marked by selective ownership and an examination to demonstrate ability.

Properties of paths

Because rites of passage *are* paths to positions, privileges, etc., they vary in the dimensions described as belonging to paths.[3] These were number, approval, effectiveness, efficiency, clarity, accessibility, substitutivity, congruence and cognizance. The modal tension loading of a people directly related to these path properties as ways of unloading tensions will be illustrated, using as a model the transition from an unwed to a married state. Simultaneously it is intended to suggest both the stresses in the situation and the applicability of the analysis of paths.

In the U.S.A. there are a *number* of ways to signify interest in and enter into marriage. Some have more *approval* as being more consistent with our ideals and norms of courtship and marriage—being presented to society, going steady with the boy from the home town, marrying up, a church wedding vs. a "lonely hearts" contact or a "forced marriage" or a "whirlwind romance" with a civil ceremony or without blessing of church or legal code.

The *effectiveness* of courtship techniques varies. Do the questing, waiting girls who hopefully follow the paths of self-adornment, self-development and display outlined in huge quantities of our advertising and fantasy media get mates? The time and energy devoted to this process of facilitating "natural selection" indexes the *efficiency* of these paths. The *accessibility* of these paths refers to the number of persons who can find a given path potentially effective. It is not known how many people follow such patterns as there are for finding a mate and are yet unmarried. *Clarity* of paths toward marriage varies because what a woman or man should do to get a mate is not explicity defined.

The *substitutivity* of paths (not objects) seems limited by personality constraints and awareness of the "art of courtship." Once set on a course with marriage as a goal, how possible is it to shift or reverse one's approach and substitute other paths? *Congruence* of paths poses this question:

[3] Arsenian, John and Jean M. Arsenian, *op. cit.*, 378–80.

Do the number of paths converge upon a goal and to what extent are these in opposition? To be flirtatious is to attract, yet to be overly flirtatious is to risk being considered "loose" and hence not a good choice for a monogamous match. Lack of congruence is well-instanced by premarital intercourse where consummation may have the totally opposite effects of guaranteeing a marriage or of blocking a marriage.[4]

Finally, to illustrate *cognizance* the question is: How much do people know about the properties of paths, in this case courtship techniques, their number, effectiveness and so on.

All rites of passage may be viewed in part as paths. As such they have the attributes of paths as illustrated above in reference to courtship and marriage. The derivative argument is that psychological tension or tension load depends upon and varies with the properties of paths as means of reducing tension. A culture's rites of passage may make for easy tension reduction or the converse.

Imbedded in the rites are psychologically and culturally important needs and goals. That they are the subject of special cultural elaboration itself shows their high tension value in much the same way as do laws or taboos.

[4] The writer knows of a Don Juan who, being both glamorous in looks, profession and skillful in courtship techniques, discarded a dozen attractive blondes because they finally capitulated to his very winning approach. He married the first one who finally defended herself.

[5] In this connection I recall reading of a culture exceedingly tough on all adolescents who aspired to marry. As the incest taboo had been generalized to include everyone, all choices were taboo and in order to wed, a loving couple had to flee to a remote haven at the peril of their lives. Once they reached this haven they were safe although in transit they were pursued with deadly intent.

Transitional supports

Leaving one position or stage and entering another may or may not be stressful depending on cultural arrangements or social habits. The arrangements between one position and the next one are here called transitional supports. In nature, metamorphosis is characteristically associated with structural supports, quiescence, shelter and often with an automatic unfolding of an innate pattern of readiness which equips the individual for its next stage. In man the possibilities are greatly varied by cultural differences.

In a newly synthesized culture or in one which has permitted or forced itself to change, transitional supports may be weakened, neglected or totally lost. For example, the onset of puberty is a definite transition, but in the U.S.A. it is not supported by any rite of passage, any recognition of maturity or any bridge to or allowance for an approved outlet for tension. It is generally ignored. Any *bio-social change for which there is not adequate transitional support is necessarily tension loading.* To illustrate with a more social need, to be graduated from college is a transition. The possible ambiguity about "what next?" or the question, "Has one the techniques to make a living?" attests to a deficiency in transitional supports.

It seems possible to take a step beyond asking whether transitional supports are present or absent. To some extent they must be present or the very survival of a group would be threatened.[5]

The meaning being assigned to the term transitional support is figuratively suggested in the model of an old-fashioned, two-part unsynchronized drawbridge. There is the staging of the whole, the slope of the approach, the width of the gap, the load limit, the force and machinery necessary

to open and close the bridge with possible differences in the lifting and lowering power and speed of the two sides. The result may be a smooth, bumpy or delayed passage, even one involving risk of falling through, or being so frightened at the approach that one withdraws, or one may be so "keyed up" about the passage that displeasure follows at being let down. For example, there are those for whom the wedding night is a disappointment.

The idea of transitional support is broader than rite of passage. In the bridge analogy, the *rite of passage* would be to the total structural and functional concern, like the act of paying the toll. Or to use again the biological phase of puberty, a *rite of passage*, if we had one, might refer to the ceremonial recognition of puberty by some initiation rites. Transitional supports would refer to all knowledge, techniques and behaviors put at the disposal of the individual prior to and following the event of puberty and provisions for the increment of tension associated with the change.

Transitional support may involve various "parts" of a culture. Thus customs, laws, sets of skills or materials, a body of knowledge or beliefs, a set of social techniques, privileges or positions may all be seen as transitional supports.

IDEOLOGICAL STRESS

Inconsistency, incongruity, discontinuity

Cultures are habits of seeing, believing, feeling, thinking and valuing as well as habits of doing. Ruth Benedict showed brilliantly that a patterning of these elements exists to the extent that a given culture has selected from all possible ways a more or less well-knit cluster, making possible bio-social survival. The whole is meaningfully integrated but the fragments that do not fit are here the focus.

With the term *ideological stress*, reference is made to discrepancies in thinking, feeling and valuing to the extent that conflict and tension may arise.

Part of this idea is familiar and variously stated as a conflict between theory and practice, ideals and reality, aspirations and expectations. Another part, also commonly noted, rests on the possibility that the values themselves may essentially conflict.

Familiar illustrations of discord between theory and practice are Christian charity and acquisitiveness; the fatherhood of God and color discrimination; Christian love and war; equality of opportunity and nepotism.

Discrepancies between theory and practice as a source of mental discomfort and confusion are abundantly testified to in newspaper editorials and Sunday sermons. That they create tension is self-evident. Whenever one is brought into focus, heated arguments may follow and some adolescents literally go wild over them, e.g., the conflictual values of purity and "sophistication."

Most adults affect a boredom or impatience or develop "logic-tight compartments" (Hart) to protect themselves against these inherent contradictions.[6] Part of becoming adult is "going through a phase" of questioning, doubting, being confused and—hopefully—"finding" one's self.

Opposed values as a kind of ideological stress are also productive of tension and discomfort. They may not be so obvious as the discrepancies between theory and practice, nor are they understood as part of the adult's secrets which bind the wounds of disillusionment with the comforting mantle of adulthood. In theory Santa Claus brings presents, but we adults all

[6] Hart, Bernard, *The Psychology of Insanity* (New York: The Macmillan Co., 1936).

"know better" and there is some satisfaction (a reduction of tension) in knowing that there *is* a difference between theory and practice. It proves one is worldly and knowing. But where the values themselves conflict, there is no such consolation in knowing. One is a bore or crank for thinking about it, a pariah or rebel for speaking out, or perhaps a dangerous revolutionary. Yet the fact remains, that there are conflicts in values and they do produce and foster tension even in people who studiously ignore them.

Illustrations can readily be drawn from major tension involved areas of living in U.S.A. culture: property, life, liberty, love, sex, age and moral goodness. The possibility of confusion, uncertainty with difficulty in choice, discomfort in confrontation, or denial of implicit contradictions—all hint at tension loading. Freedom vs. hard work, virtue vs. sophistication, filial devotion vs. independence, submission vs. self-assertion—some combinations of these are potentially tension loading.

A third type of ideological stress was described by Ruth Benedict who focused on *"discontinuities"* in the socialization process. Some tension invested or tension reducing activity or ideal emphasized in one stage of the life cycle is displaced, deflated or discarded later. There is sometimes literally a reversal of attitude or value. Children are instructed to be obedient, co-operative and peaceful, rewarded for this behavior, sometimes punished for transgression. But the time comes when they advance their interests more if they are assertive, competitive and aggressive. For some more than others the early conditioning sticks. What is later in order is not a good continuation of what came before; hence the term discontinuity.

To illustrate from other age groups: the practice of retirement at 65 with benefits and assistance conflicts with adult goals of industry and self-support. Again, the license or demand for murderous aggression in wartime from persons earlier indoctrinated to check ideas and impulses toward extreme violence produces a stress rendering some unsuited for wartime service and contributing to others' neuropsychiatric discharge from military service. Or consider the grown-up girl who wants supremely to be loved, attracts a mate and finds her happiness threatened by the prospect of competition from her own child and her sanity threatened by this appalling thought. She who was so happy to receive so much love now is expected to step aside and give love. Again there is discontinuity between the emphasis on irresponsible play in childhood and on responsible work in early adulthood, or on dependency in childhood and youth and independence in adults.

Such discontinuities are potentially productive of sustained tension, especially in persons who lack either brightness or resiliency and are consequently inflexible or rigid.

Most of these situations may be seen as special types of value conflict where the culture changes its moral expectations with time or circumstances and for one reason or another people fail to accommodate.

Temporal discontinuities

There is another type of discontinuity clumsily expressed as those *too soon or too high built up and too soon or too far let down.* The arena of sports provides the easiest example; the high school or college football star must find it hard to be a "has-been" at 20 or 25. True, the high school star may go on to be the college star, although the competition is stiffer, and he may not "make the grade." Even so, except for a handful who become professionals,

this path toward fame evaporates upon graduation.

Perhaps the same may be said of young fliers who achieved such honors, titles, salary and admiration for their risky wartime service as they may never again achieve. Or, less recognized in the framework of our society, the natural leaders of youthful gangs may never again enjoy such power and prestige. That they early enjoy an enviable position on the corner or in the neighborhood may operate against their struggling for recognition within the framework of socially approved adult society. Hence their natural talent for leadership, if it goes unsocialized, may predispose to social failure or outlawry.

Self-evident in its stressful quality, the discontinuity of being too highly built up and too far let down finds examples in those who "also ran," the defeated candidate for office, the runner-up in a race or contest, those also nominated or considered, those, in short, who might have been chosen had fortune smiled. Unlike those too soon built up, years of hard work, grooming and self-discipline may have preceded the critical test. Those who "also ran" may suffer not only the gall of defeat but also the embarrassment of struggling to regain their prior level of esteem once the aura of ascent has flared their reputations and aspirations. With defeat may come ruminative fantasies of revenge and reversals which aggravate the spirit, adding the tension of guilt to the depression from defeat.

One other subclass of discontinuity merits description. Its commonness is attested to by the familiar complaint "*if only* I had known." Metaphorically the reverse of the youth who flies too high too soon, this is the person who does not get off the ground through the fault of proper training or timing. For those who could have "made the grade" had they taken the right steps at the right time, the discontinuity lies in their failure to realistically anticipate the level at which they should or must be operating to achieve their aims.

The foregoing material details some of the more environmental or cultural factors promoting high tension. What follows gets closer to the individual, to the needs that are frustrated, with resulting increased tension, pushing people toward their individually variable breaking points.

LOSS

Situation of loss

First there is the *situation of loss,* most literally illustrated by the death or removal by divorce and separation of some loved or significant person who served as the mainspring, mainstay or reservoir of tension reducing activity.

Clinically, losses are associated with depression, melancholy, longing for restoration and sometimes with maniacal excitement like running amuck or suicide.

Loss is generally publically recognized and usually gets some sympathy, support and consolation. The adequacy and regularity of substitute provision is the critical factor in determining how much tension the bereft individual will be required to bear. Cultures vary widely in their provision for the various kinds of loss.

The biologic losses of potency and fertility associated with the climacteric or "change of life" regularly contribute to depression, even in women who have demonstrated their fertility.

More subtle are losses of a psychological type such as loss of ideals about the self or marriage or about the ultimate value of things. Loss of real competences or failure to develop hoped for levels of skill may likewise produce depressions.

Chronic insufficiency

The term *chronic insufficiency* is introduced to describe those situations in which an individual gets some gratification for needs but *not enough*, like a substandard diet. Different from *loss* in that a person does get something, chronic insufficiency may go without public or even subjective recognition. For this reason it may be cumulatively productive of as much tension as *loss* which is overtly recognized and sometimes adequately compensated for. The constancy and prolongation of the deprivation may produce some habituation to unhappiness of the sort William James had in mind in his famous phrase, "Habit makes victims of us all."

Chronic insufficiency seems clinically associated with malaise, anxiety, discontent, mild depression, irritability and various hypochondrial complaints such as colitis and ulcers.

Such serious consequences presuppose that the "needs" involved be central to well-being and happiness. Beyond the more physical needs of food, clothing and shelter, this notion is built around more psychological needs such as sex, affection, security and self-assertion and self-esteem. Karen Horney's book *Neurotic Personality of Our Time* (1937) is an excellent outline of the neurotic and characterlogical consequences of what is here called chronic insufficiency. Franz Alexander's classic summary of the relation between chronic frustration of passive dependent needs and duodenal ulcer establishes the possibility of physical or tissue illness from chronic tension associated with insufficient gratification of psychologic needs.

Central need frustration

To describe *central need frustration* as the absence of gratification of some pivotal, vital need may seem repetitious in view of the preceding. Some clinical material seems to warrant its separation from "chronic insufficiency." What distinguishes the two is a quantitative factor in respect to both degree of response and vital significance of the need. Where chronic insufficiency or deprivation may produce responses of the order called "neurotic," central need frustration may drive people "stark raving mad." As in battle, psychosis, the desert mirage, running amuck, jealous mania—needs which are close to survival when frustrated—may produce a violent response or a profound disorganization of personality.

Central need frustration may be associated with violent or murderous assault on the self or others. It may also be associated with obsessive trends so powerful and demanding as to render the person functionally psychotic. The obsessive traits appear to evolve to forestall murder of the self or other one or to defend against the use of the sexual centers as a means of discharging tension.

Central need frustration is more often clinically associated with other psychiatric syndromes; literally any and all schizophrenic reactions are possible consequences. Shakespeare's Ophelia illustrates fairly well the shattering of personality following the shattering of love's dream. Frustration in aspiration for high achievement is obviously associated with some paranoid schizophrenias.

Moreover, the *depressive syndromes* are inevitable consequences of central need frustration since the person is missing something and naturally feels sad and grieved about it whether he is additionally angry, outraged, driven berserk, beside himself or out of his mind.

Perhaps it is not oversimplification to say that central need frustration may produce psychopathology—all types.

Catastrophic loss

Catastrophic tension refers to the sudden or sustained threat to life most common in natural disasters or modern warfare. Tension beyond loading capacity produces random motor discharge, purposeless activity, possibly primitivization or regression of behavior—among other kinds of disturbances.

In combat line or target, threat to survival may give rise to varied neurotic reactions. The book *Men Under Stress* by Grinker and Spiegel[7] well-illustrates the onset of symptoms where there is a sudden or more gradual accumulation of irreducible tension. Where threat to life cannot be concretely defended by some protective work, it may produce incapacitating anxiety, compulsive activity, insane flight toward the enemy or severe regression.

John Hersey's *Hiroshima*[8] includes numerous examples of crazed behavior associated with a sudden overwhelming stimulus. That there may be similar responses to the signal of a catastrophic event —even if a false alarm—was documented by Hadley Cantril's study[9] of some folk reactions to Orson Welles' dramatic "War of the Worlds," the 1938 radio documentary based on the book by H. G. Wells. In *Hiroshima* something unknown and dreadful had happened. In "Invasion from Mars" something dreadful was immediately anticipated. Both produced similar irrational activity showing some vestigal survival aim, but the organization of the behavior was clearly lacking.

The kernel of the argument is that sudden catastrophe produces behavior which is similar to transient psychosis, whether there be a reality basis for the panic or a threat or anticipation of disaster as in other panic situations.

The last straw

It is both popularly and philosophically recognized that fate is sometimes uncommonly cruel. A stressful sequence of events may be capped by yet another trial or tribulation that proves beyond endurance. The popular image of the "last straw" or "the straw that broke the camel's back" seems lively and valid. Whether it is called a breaking point or a threshold for decompensation or personality disorganization is immaterial. The basic idea is sound: a man can endure so much. Beyond this the next frustration, annoyance, aggravation, insult or wound (or to use our language, the next increment in painful tension) may trigger a massive psychotic reaction, ranging from mute stupor to maniacal furor.

The language of historians which separates the *underlying* and *precipitating* causes for catastrophic events such as wars, revolutions and depressions may be relevant here, for personalities do indeed undergo these trials to their integrity.

It may be worth noting that the particulars associated with the "last straw" may or may not be related to the central issue. Thus it is of variable significance and use in attempting to reconstruct or understand the causes of an illness. Commonly there is at least a symbolic link between the precipitating stress and the underlying tension state.

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[7] Grinker, Roy R. and John P. Spiegel, *Men Under Stress* (New York: Blakiston Division, McGraw-Hill, 1945).

[8] Hersey, John, *Hiroshima* (New York: Alfred A. Knopf, Inc., 1946).

[9] Cantril, Hadley, Hazel Gaudet and Herta Hertzog, *Invasion from Mars: A Study in the Psychology of Panic with the Complete Script of the Famous Orson Welles Broadcast* (Princeton, N. J.: Princeton University Press, 1940).

CONFLICT

Conflict is a central and pivotal concept in most "dynamic" theories of abnormal psychology. Because the focus here is on situational factors, attention is called to types of conflict which are, relatively speaking, external to the personality although the values or things involved may be of the utmost concern to the person. This use of the term is different from the intrapsychic conflict so integral a part of psychoanalytic theory.

Where psychoanalysis has well-developed theories about parts of the personality in conflict, the conflicts referred to here are more matters of decision and choice between manifest alternatives. Kurt Lewin provided a systematic analysis of the types of painful choice in a masterful paper on "the psychological situations of reward and punishment." [10] Much simplified, the few situations outlined below have recognition in images and metaphor that are centuries old.

First is the conflict of being compelled to choose between two positively attractive goals, aims or values, proverbially instanced by the plight of the ass that starved to death, caught equidistance between two haystacks.

Second is the conflict of being constrained to stay in a situation and choose between two unpleasant aims, goals or values. Folk wisdom has it that one should choose "the lesser of two evils," but people have also long recognized the more trying state where the choice is "between the devil and the deep blue sea" or "to jump out of the frying pan into the fire."

Third is the conflict of ambivalence: one and the same goal, value or aim simultaneously attracts and repels. The idea of the too costly Pyrrhic victory or Aesop's fox's "sour grapes" catches part of this situation.

Finally there is the situation where each opposed alternative gives the prospect of pleasure and pain. While this is a combination of two of the above conflict situations, so many choices either present or develop in this way that it warrants independent specification. Perhaps the idea is caught by the expression: "Six of one; half dozen of the other."

Clearly all four situations have in them the possibility of increments of tension, the more so if the choice is of vital significance to the person and decision somehow delayed. Below "P" signifies the person and the symbols + or — designate the attraction or repulsion value of alternatives which may be things, activities, persons, etc.

$$+P+$$

By turn to illustrate the fit of these models to clinical material, an attractive girl who felt unattractive blossomed on discovering the unreasonable source of her negative self-feeling. (Her mother appreciated her handsome brothers much more and felt the girl would have to be accomplished to be admired.) Feeling better, she quickly attracted two suitors, each having many admirable traits. Unable to choose between them, she became simultaneously engaged to both. As she did so she became, by turn, excited and depressed. Her inability to choose was responsible for a large increment in tension and some nonrational behavior.

$$-P-$$

The pathological potential of a situation in which one must choose between two negatively valent situations may seem more self-evident. Consider, for example, the

[10] Lewin, Kurt, *A Dynamic Theory of Personality*, (New York: McGraw-Hill Book Co., Inc., 1935), Chap. IV, 114–70.

situation of a passionate woman who was bitterly frustrated in a growing estrangement in her late marriage. She loathed the alternatives of separation and continuation in a marriage with her unfaithful husband. Ideas of killing him, herself and their child entered her mind. She would not let her husband get away with two-timing her. But these ideas were intolerable.

The doubly intolerable choice of "letting him get away with murder" or murdering him was disguised by this delusion: some gang was out to get *her* and the child, and her husband was a Secret Service agent and, therefore, necessarily absent from home.

$P \pm$

The situation of ambivalence, so well-illustrated by the soldier who wants both to stay and take flight, may be again illustrated by a patient who loves to drink for the taste and the feeling of freedom from her marriage vows, yet who so overindulges that as often as she drinks she is returned to the hospital, usually after some violent scenes. She genuinely loves and hates liquor, and the ambivalent feeling itself produces a state of tension such that she either feels explosively anxious or goes on a drinking craze to seek oblivion.

$\pm P \pm$

The fourth situation is illustrated by a young woman who had taken steps toward entering an extremely ascetic order of nuns. She genuinely wanted to live a devoted spiritual life, but this ran counter to some suppressed interests in leading a more normal young adult life. She avidly read magazines of the *True Story* type while professing to abhor the lustful side of normal life, being afraid of men and sex. She was both attracted to and repelled by both alternatives. The struggle became too much for her and she "cracked."

In all these situations of confusing and conflicting choice, it is hypothesized that the tension level mounts to progressively more painful and unmanageable pitches. As repeatedly stated, either the personality gives way under the tension or the outward behavior shows the signs of distress.

In reviewing and recording the life histories of several hundred patients, with but few exceptions there emerged salient, conflicting feelings centered around the biological events of birth, weaning, accession to manhood or womanhood, discharge of libido, reproduction, marriage, separation, divorce and death.

As previously intimated, some of these biologically based, emotionally troublesome issues can be rendered less conflictful by changes in structural supports so that people will have lessened tension loads.

As for the more external and socially centered aspects of conflictful choice, it has been noted that the richness of the United States, together with its relatively classless society, its ideology of individualism and freedom of opportunity, presents citizens with many alternative courses of action, careers, positions and personal choices. Where multiple opportunities require choices which eventuate in different degrees of reward or satisfaction, increments of tension (tension residuals) are left for all choices which are less than satisfactory.

If "the grass is always greener on the other side," America presents many pastures with many fences and many gates which may in one way or another be opened or hurdled. To the extent that the gates are open, the ideology of individualism has it that a man has "only himself to blame" for failure to get what he wants. The possibility of resulting self-dissatisfaction would be associated with increments in uncomfortable tension. To the extent that

some gates are, in fact, closed and some opportunities chimerical, the conflict between an ideology of free opportunity and the reality of barriers defines a type of stress which is itself productive of tension.

Assuming that the several factors delimited point to some situations as potential generators of high levels of tension for any considerable number of people, it follows that changes in cultural and socializing arrangements could do some things to reduce and eliminate some stressful situations.

The idea is not new that civilization is pushing many people toward "breakdowns." Current practice in psychiatry so occupies that profession with those who are emotionally crippled or overburdened that more attention is given to the analysis and possible resynthesis of these individuals than to those aspects of the societal matrix which promote mental illness.

Chiefly through the development of "structural supports" and the regular introduction of substitutions for various kinds of loss, there seem to be possibilities for lessening tension loads without altering the values or habits of our people.

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LESTER A. GELB, M.D.

Personality disorganization camouflaged by physical handicaps

Evaluation of a full variety of physically disabled or chronically ill outpatients at the Institute for the Crippled and Disabled, New York City, has uncovered many instances of serious mental disturbance which were not previously recognized. Mental disturbance in individuals who have sustained physical disabilities is a well-known phenomenon. Ruesch (19) believes that the problem of prolonged convalescence or invalid reactions among the physically ill probably surpasses that of mental disease in social importance. Perhaps it would be more reasonable to include many of these cases of "prolonged convalescence or invalid reactions" in the category of mental illness. Certainly it is a psychiatric problem which is not adequately met.

It is the aim of this paper to consider the probability that the degree of disability in many handicapped patients is enormously magnified by unrecognized mental illness and to outline the dynamics involved. The Institute for the Crippled and Disabled is a comprehensive rehabilitation center affiliated with New York University. At this center patients can be studied and treated in a setting where their reactions to a variety of social, vocational and physical situations can be closely observed. Intake social workers at the Institute interviewed 1,391 patients in the 26-month period between January 1, 1957, and February 28, 1959. Of this number, 545 (or 39 per cent) were provided with some form of continued psychological help, including psychotherapy, by the staff of our Social Adjustment Service. An estimated 15 per cent were also recommended for psychological help but either refused it or were not considered suited to the

Dr. Gelb is Director, Social Adjustment Service, Institute for The Crippled and Disabled, New York City.

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full rehabilitation program. A larger number (64 per cent) of the congenitally disabled were considered to be in need of such services.

It is well-known that many mentally disturbed individuals claim a physical basis for their condition. We might, then, investigate those physically handicapped individuals who, we find, have a personality disorganization, with the hope of learning more about the role and value of physical disability to the mentally disturbed person. Certain neurotic individuals find nonexistent illness a useful blanket or camouflage to cover their neurotic way of living. Actual physical disability can serve that purpose with even greater success. The following is an example of a case of an actual physical disability which camouflaged a serious mental illness.

Case 1. The patient was a thirty-year-old single woman who had received medical and surgical treatment in various hospitals for a ruptured lumbar vertebral disc. For three years no cognizance was given to the serious psychiatric disorder which was ultimately seen to be responsible for the greater part of her disability. Two and one-half years after her back injury occurred, an insurance carrier referred her to our Institute for treatment for her back. Patient and physicians alike busied themselves with her severe physical symptoms. A myelogram and further surgery were recommended but refused by the patient.

After six months our Medical Service referred her to the Social Adjustment Service because she had made no progress and was depressed and preoccupied with back pain. At first she attributed all her troubles to her physical condition but later, with help, she was able to tell her social worker of her tortured and disorganized life, of "emotional bridges" she felt had to be crossed before she could work again. From that point on the patient seldom referred to her physical complaints. The psychiatric interview and psychological testing revealed a serious personality disorganization, with depressed intellectual functioning, depression, paranoid ideation, phobias and hysterical reactions which seemed to be a defense at times against schizophrenic panic.

The patient was considered to be a borderline paranoid schizophrenic. She continued in psychotherapy for two years, and although she remained a very disturbed woman, she had improved considerably. She was able to benefit from physical therapy, no longer required it, and was able to use public transportation. For the first time in five years she was psychologically and physically ready to accept employment.

PSYCHOLOGICAL REACTION TO DISABILITY

The manner in which a physical injury or illness affects an individual psychologically has been viewed in various ways by different observers. Freud (10) and Ferenczi (8) believed that a sick or disabled person withdraws love and interest from others and transfers them to himself or his diseased parts, thereby becoming "narcissistic." Ferenczi called these narcissistic neuroses "pathoneuroses" if they were consequent upon somatic disease. Anna Freud (9) looks upon the effects of illness as being primarily due to "changes in libido distribution" and to the heightened demand of the ill body for "libidinal cathexis." In the field of rehabilitation increasing attention is being paid to the importance of the pre-existing personality as it relates to the degree of pathological reaction to the disease or handicap (2, 3, 11, 12).

Alger and Rusk (1), in a paper describing the rejection of help by some disabled people, emphasize that "the neurotic reaction is not something new brought about by the disability. Rather, the neurotic reaction to the disability is only another

example of the specific patient's typical way of reacting to stress situations in life."

They describe a patient who required psychotherapy because his neurotically competitive character interfered with his rehabilitation. In this case the patient's prideful scorning of help and violent assumption of independence was erroneously looked upon by the patient, and some others, not as neurotic but as an expression of courage and fortitude.

Bychowski (5) describes a case of a girl at the Institute for the Crippled and Disabled, who required psychotherapy primarily because of her seclusiveness. Before the onset of her severe disability she protected herself from "lowly" sexual impulses because they were inconsistent with her feelings of lordly superiority. Even her own attractiveness as a woman was unacceptable to her. When she became handicapped she used her disability to suppress her female role. The disability became a convenient camouflage for distorted, neurotic sexual attitudes.

Ruesch (19) noted in a statistical study that of all the major conflicts associated with delayed recovery, dependency-independency ranked first. The frequent overdependency of a physically ill patient is often seen as "regressive behavior." The author does not feel that such pathological dependency is a regression but rather an *expression* (in the framework of the illness) of the individual's typical way of functioning. This neurotic expression may not be seen by either physician or patient as neurotic because of the realistic dependency of a handicapped person, which is not easily separated from neurotic pathological dependency. In other words, neurotic dependency may "look good" when one is handicapped. We have seen, in fact, many patients (perhaps included among them the huge number of "prolonged convalescence or invalid reactions" cited by Ruesch above) who *seem* adjusted and "merely" handicapped, but who have personality disorders or neurotic reactions such as pathological dependency, schizoid personalities, paranoid reactions, phobic reactions, etc., but these disorders are more or less unseen. In many cases the injury or physical illness establishes a situation which is more congenial for the practice of a preexisting neurosis or psychosis. It is therefore understandable that some individuals with a personality disorder would welcome a physical illness or disability. The following is an example of such a case.

Case 2. The patient, a thirty-year-old welder, sustained a superficial one-inch laceration of the right forearm. Eighteen months later he was referred to the Institute by an insurance company. Before referral he was seen by at least 12 consultants, none for psychiatric evaluation. Yet because of bizarre and inconsistent neurological findings, most of these physicians felt the patient had a conversion reaction. Two of them advised surgery. Despite a variety of treatments, he reported that his arm pain increased. The patient would not use his arm. He had stellate ganglion blocks, steam packs, paraffin baths, ultra sound and other physical therapy.

At the Institute he was not considered physically handicapped. Evaluation in the Social Adjustment Service revealed a man with very little anxiety. He casually spoke of somatic symptoms and related stories of poor treatment following his accident. He had resented his mother's and nine siblings' expectation that he contribute to their support; he had married but left home four times; he had had a succession of many jobs in 10 years. In psychological testing he made a minimum of effort and actually reacted with amusement to repeated failures. The patient's buoyancy and joviality reflected his satisfaction in proving his inability to function and his expectation that others would now have to take care of him. The patient was diagnosed

passive-aggressive personality with hysterical and paranoid features. He would not accept anything but physical "treatment" and he left the Institute to continue passively to receive this elsewhere.

In this case the individual was almost overjoyed with the existence of a fairly minor injury. He exhibited behavior which was a continuation of his pre-existing personality.

EFFECT OF PSYCHIC TRAUMA

Mental and physical reactions to a catastrophic event, in the form of traumatic neurosis or traumatic syndrome, may also provide a form of camouflage for a basic personality or mental disorder.

In studying patients who were injured in both world wars, it became evident that the mental behavior of a patient following an injury was often more important than the injury and that it often bore little relationship to the type or extent of the physical injury. Kardiner (13, 14) views the traumatic neurosis as resulting from a breakdown of the executive system for action. He does not find any consistent patterns in the pretraumatic personality. It should be noted that Kardiner studied only those cases where traumatic neurosis was considered to be the exclusive picture, and not those in whom the trauma is woven into the character structure or those in whom psychoneurotic symptoms and traumatic neurosis coexist. Although Kardiner emphasized the specificity of the traumatic neurosis, the current classification of psychiatric disorders officially adopted by the American Psychiatric Association does not include traumatic neurosis. Several other workers in the field have felt that this condition cannot be separated out so distinctly. Kelman (15) considers it a "decompensation syndrome" following an injury. The traumatic syndrome does not develop in individuals whose injury or illness does not detract from their neurotic way of living. Kelman emphasizes that the prominent character trends of the patient are crucial and that the pretraumatic personality can be understood from the study of the patient who is reacting with the "traumatic syndrome." Bonime (4) provides an example of a patient's chronic and severe neurosis, following traumatic war experiences, as something that developed in terms of his previously existing personality disturbances. At first all that was visible was a seemingly helpless victim of painful war experiences. Psychotherapy made it possible to place the war traumata in their proper perspective along with problems that existed long before. Here the reactions to the war experiences were sufficient to camouflage the basic disturbed personality.

The author views the reaction of a patient commonly diagnosed traumatic syndrome or traumatic neurosis as basically a reaction of severe anxiety or panic, some symptoms of which the patient incorporates into a fixed, chronic defensive system. The panic is provoked by actual or threatened destruction of a previous neurotic or psychotic way of existing. If severe, it may be similar to or the same as the panic seen in the schizophrenic crisis (17) and such a crisis may actually occur. An obvious injury or physical disability accompanying such a case may be of value to the patient as a secure screen behind which his neurotic practices can be carried on undetected and unmolested. In the following case the patient attempted to convince himself and others that all his problems were due to his injury and had not existed before.

Case 3. The patient was a thirty-four-year-old former iron worker who, two years before admission, fell three stories and sustained multiple but only temporarily disabling bodily injuries. An orthopedic surgeon who examined him

six months after his injury found no physical defects and recommended psychiatric rehabilitation. The insurance company concerned did not refer him for psychiatric consultation, however, and one year later he was referred to the Institute by another agency for vocational rehabilitation. Our medical examination yielded no physical diagnosis. His symptoms of head, neck and leg pains, memory lapses, enuresis and impotence were considered part of a psychiatric syndrome. He appeared to be in a chronic state of agitation and anxiety.

When psychotherapy was begun, he at first saw no problem except that his symptoms made him feel hopeless about returning to his "happy" preaccident situation. As a child in Europe he had been exploited by his cruel father and employers. He cynically viewed all interpersonal relationships as being between master and servant. He had achieved "success" by means of what might be termed a "dutiful maneuver," presenting himself as a subservient and grateful conformist. His confidence in the sufficiency of this role had already been shaken when, as an adolescent in war-torn Europe, he continually suffered from deprivation and danger of death. In America, his obsequious behavior kept him anxiety-free until his accident occurred; then his confidence was almost completely shattered. He was physically no longer able to cater to others. His subsequent depression and anxiety were in proportion to the threat to his long-standing pathological adaptation. Since he viewed all people as cruel, he attempted to get along with them by continuing to remain compulsively beyond reproach.

His seemingly strong motivation to return to work was merely a response to what others seemed to expect from him. His suffering was masochistically "self-punishing" and thereby a means to ward off the expectations and reproaches of others. He never became deeply involved in psychotherapy but after one year he began to sense that others could accept him even when he was not subservient. He was no longer impotent, recently married and began to get satisfaction from his training in electronic wiring.

THE MYTH OF ENNOBLEMENT THROUGH SUFFERING

Fenichel (7) believed that "the opposite of a pathoneurosis would be a 'patho-cure' of a neurosis that disappears with the outbreak of an organic disease." In other words, the neurosis becomes superfluous when replaced by another kind of suffering. He felt that it is not uncommon for a neurosis to spontaneously improve if a kind of "secondary" or "artificial" neurosis takes its place. For example, according to Fenichel the neurotic may "get well" if he falls physically ill or suffers a real misfortune because the misfortune takes over the "punishment significance that had been represented by the neurosis." There are reports that schizophrenia has improved or remitted when organic illness such as TB or pneumonia intervened.

A disability may establish new conditions for a person which alter the manifestations of a neurosis, but the disability cannot cure or basically change a neurosis. Where such appears to have occurred the neurosis is merely camouflaged, blended in neatly so that it is not visible. It is just as active and often more effective than before. On the other hand, in a time of crisis, which may occur following an injury, an individual may discover healthy resources which he did not use before. If such unexploited capabilities are unearthed the person may have the opportunity, in particular circumstances, to learn the value of his strengths and as a consequence move closer to health. But even in such a case a physical handicap does not "replace the neurosis."

A vivid expression of this point of view comes from the pen of a mature and perceptive writer and philosopher (20) who,

rendered immobile following traumatic transection of the spinal cord, writes that he does not believe suffering has the effect of changing people for the better. He states that on the contrary, from his personal experience and from his study of history, it appears people change rather for the worse when subjected to serious physical and mental strain. But he suspects this is possibly a kind of optical illusion. "They probably did not really change at all. They remained what they were, only more so, because their most essential, normally perhaps hidden characteristics suddenly became visible on the surface. The very useful and . . . protective shell formed by certain civilized conventions, pretensions or inhibitions was usually quite thin. It peeled off easily under pressure and revealed every single individual in his naked truth. . . . What really happened was that in such a test the individual gave irrefutable testimony about himself, about his basic ugliness or his fundamental decency or even the rare nobility which proved to be the deepest core of his being. The evidence so produced was sometimes rather startling, not only for others but for himself. Perhaps it was the rare occurrence of happy surprises of this kind that fostered the naive illusion that every personality was necessarily purified and ennobled by suffering."

PERSONALITY EXPRESSED BY THE ILLNESS

The cases so far presented illustrate that a physical disability may precipitate, aggravate or obscure mental symptoms. Not only is there an emotional reaction to the disability but the symptom components of the disability itself may be used to express the pre-existing personality and become part of the neurotic pattern of living. For example, Grayson (12) made note of the fact that a paraplegic may use the symptom of incontinence as a means of expressing hostility or accentuating dependency. Thus, physical and mental reactions to a disability may at once express and also mask the basic pre-existing personality disturbance. The following case illustrates this phenomenon:

Case 4. The patient was a forty-two-year-old man who had been paraplegic for eight years. His rehabilitation had been seriously retarded because of his personality disorder. His handicap followed the use of spinal anesthesia during surgery for stomach ulcer. Although he was a skilled and respected worker in an industrial workshop, his attendance was extremely erratic because of bouts of depression and alcoholism. He attended the Institute weekly for psychotherapy.

The patient's despondency always followed occasions when he felt his needs and desires were neglected by others—a delay in repair of his braces or failure of a relative to write to him. At these times he sulked, neglected to use the toilet facilities at his boarding home or at work and became incontinent of urine, much to the annoyance of those about him. At other times he got drunk on cheap wine which he bought with his rent money. He then made many phone calls announcing that he was too ill to continue the struggle. One crisis followed another and psychotherapy was only partially helpful.

He rarely expressed anger directly and he was usually ingratiating and conforming. He was the same way before the onset of his handicap. He had been married twice and in each case his wife had left him. In describing his marital life, he boasted that even though his wives were high-strung and shouted at him, he remained reasonable and unruffled; at these times he would walk out until they "cooled off." This patient was a passive-aggressive personality who had not been basically changed by his handicap. He was passively demanding of others and became depressed when he

had to actively give in a relationship or when he had to reveal his need for others. He used his own handicapped body vindictively and masochistically to punish others when he was frustrated. In this case we can see not only a reaction *to* the illness but also the use of the illness to express the pre-existing personality.

INFLUENCE OF SOCIETY AND THE FAMILY

The attitudes of others should not be overlooked in considering the vicissitudes of personality disorganization in a physically disabled individual. The camouflages noted above may be supplied by the social environment. Meyerson (16) states that in superficial contacts with the disabled, physically normal people are influenced by a "signal reaction" and tend to see only the disability rather than the person with a disability. In our experience the signal reaction may persist far beyond superficial contact. Consequently, where personality disorder exists, physical disability may become a cover-up by the mere fact of its existence. This phenomenon is strikingly illustrated in the following case since it demonstrates that even a severe, chronic schizophrenic reaction is subject to the camouflaging effect of physical disability. The physical disability, of course, may have contributed to his mental disturbance but it also deflected professional attention away from his then primary mental illness.

Case 5. The patient, age forty, was seen at the Institute for the Crippled and Disabled in 1939, 1949 and 1956. In addition, over the span of these years he received extensive attention in six other institutions, including a mental hospital. His physical diagnoses had been: 1) undescended testes, bilaterally and 2) paralysis, right lower extremity, following poliomyelitis at age fifteen. He was repeatedly rejected for vocational rehabilitation services because of his bizarre behavior. Nevertheless in no instance had a clear-cut psychiatric diagnosis been made, although review of the copious records of previous evaluations reveals that his bizarre and disturbed behavior was identical to that which led to our diagnosis of chronic schizophrenia.

His behavior has been so grossly psychotic that I am convinced that without his physical disabilities none of his past observers would have hesitated to make a psychiatric diagnosis. In one vocational testing report (January, 1949) the following appears: "At first he was fairly quiet but then he began to grumble and grunt in a rhythmical fashion as he worked. He was very tense and would suddenly start wringing his hands, banging on the floor and wiggling. He would suddenly stick his whole hand into his mouth. . . ."

Incessant loud talking, flight of ideas, wide scattering in psychological test responses, "somatic phobias" and severe hypochondriasis were all reported in 1947 and were not different from the findings 10 years later. In 1947 a mental hygiene clinic report revealed that his "immaturity, self-consciousness and loquaciousness are probably related to a strong sense of social inferiority due to his retarded glandular development." A mental hospital where he spent a year in 1939 made this diagnosis: "Hypopituitary deficiency, other complications, mental reaction of inadequacy, prognosis poor for recovery."

He was accepted for service at the Institute in 1956 before his previous record was known to have existed. Again, despite examination by a physiatrist and an internist (where very little physical disability was found) and a psychiatric screening, the full extent of his psychiatric disability was not apparent until vocational evaluation and an intake evaluation by the social worker were begun. Further psychiatric evaluation revealed bizarre somatic preoccupation, paranoid delusions, multiple phobias, flight of ideas, inappropriate and bizarre social behavior.

Cultural values contribute to the extent to which a handicapped person feels crushed in his environment. In those cultural groupings where physical prowess, appearance or high income, etc., have high value, the task of successful adjustment with a disability is magnified. The disabled patient is often encouraged to enjoy the status quo because of the neurotic reasons of others. Neurotic manifestations such as dependency, withdrawal, denial and guilt may be encouraged or generated in a patient by family or society. For example, the feeling of false pride on the part of some families may encourage dependency. The patient may be told in actuality or in effect: "Why do you try to work? It is an insult to us. We are a big family; it is easier for us to support you."

The handicapped are segregated and isolated because of society's distorted and rejecting reaction to the crippled person, who is not seen as fully human. In referring to the mental patient Robbins (18) said: "The patient's own way of living, when left to his own devices, points consistently to isolation from others and a generally restricted sphere of activity. If our own so-called therapeutic procedures also have these characteristics, then our therapy is doing the same thing which the patient does for himself. . . ." Robbins is referring to the isolating features of the large inpatient mental hospital. In a similar way the physically disabled patient may isolate himself or be isolated by others.

Psychiatrists may share in this isolating process and thereby contribute to pessimism regarding psychotherapy for this group. Many psychoanalysts consider the disabled person to have a life situation which is "unfavorable" or too complicated to make him a good candidate for psychoanalysis. There are very few reports in the literature dealing with intensive psychotherapy of a disabled patient. The disturbed mental functioning of a disabled person remains hidden if he is isolated from the common stream of life by society's distorted concepts. The problem remains even if it is merged with his physical handicap or submerged by it, and the loss of living potential for the patient is just as great.

Since the degree of disability in the physically handicapped may be enormously magnified by unrecognized mental illness, careful psychiatric evaluation of the patient in a comprehensive setting and appropriate referral for psychotherapy or other treatment is most necessary. Rehabilitation centers for the treatment of the physically disabled must make adequate provision for the psychological rehabilitation of their patients. In most of the 1,600 U.S. hospitals, where beds are assigned for rehabilitation, no psychotherapy is offered and the psychiatrist merely participates in the evaluation of the patient's problem (6).

It is our experience that if a physically disabled patient is evaluated in a brief office interview, a problem may not be uncovered. A multidimensional approach is usually more successful. In a comprehensive rehabilitation setting the psychiatrist, psychologist, social worker and group worker comprise a Service which, along with the medical and vocational services, can provide the patient with a dynamic evaluatory and therapeutic experience. This appears to be the best setting in which to view an individual in action, to see his way of living and relating and thereby to diagnose and treat any personality disturbance which may otherwise remain unrecognized. Such a personality disturbance may augment or be equally or even primarily implicated in the apparently purely physical disability with which the patient originally presents himself.

SUMMARY

The complex of physical disability and mental illness is not easily separated into its elements. Often both patient and physician may be unaware of the processes involved, and as a result many physical disabilities are treated over a period of years without recognition of the presence of or the complicating force of neurotic or psychotic illness. The physically disabled patient responds to his total environment and uses himself in a manner consistent with his personality. In the case of personality disturbance, the physical disability may be used either to express or shield such a disturbance. Adequate psychiatric evaluation in a comprehensive setting appears to make possible the most constructive therapeutic course for the patient.

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CATHERINE T. BENNETT, M.A.

A telephone interview: A method for conducting a follow-up study

Follow-up studies have proved to be a most effective means of evaluating the gains made by former clients of agencies devoted to furthering social and behavioral adjustments. The most important of these seems to be the way in which the individual experiences his difficulties and the abilities he and those about him can develop to cope with them. Once he has had a chance to strengthen his most effective coping mechanisms and has been helped to re-educate himself to deal adequately with his problems, his need for the services of the agency is considered ended. How well he has learned to use the services of the agency and how effective they have been in helping him are the major questions a follow-up study is designed to answer.

Mrs. Bennett is a Research Psychologist at the Child Guidance Clinic in Louisville, Ky. She has been conducting a survey type telephone follow-up study since 1956. This article describes her experiences in developing and using this method.

Survey type follow-up studies are those in which all clients of an agency who asked for help during a specific period of time are investigated. The advantage of such surveys—in addition to the evaluation of the individual's progress—is that an evaluation of the effectiveness of the agency's services can be made. The purpose is directed to the agency and how effectively it can do its work.

Many follow-up studies would be attempted if there were some more convenient, less costly and less time-consuming method of interviewing than that of home visits. The telephone provides a way of making more follow-up interviews in a less time-consuming way.

The telephone follow-up interview is to be considered a research tool only if the method of conducting it is carefully designed in advance. The method described here is one which is in use at the Louisville Child Guidance Clinic and has proved of

value (1). It was devised and adapted from the description of the telephone follow-up study undertaken by the Detroit Children's Center (2). Whether it was designed and conducted in exactly the same way is not known but the method and results are comparable.

Over 250 cases were studied by 1960, the fourth year of the telephone follow-up study at the Louisville Child Guidance Clinic. We found that the telephone population is an excellent representation of the total clinic population, possibly because most people today have telephone service. When we compared our results with those of the Detroit Clinic we found agreement on nearly every dimension. This strengthens our confidence in the method. Consideration of the following factors is essential in setting up procedure:

1. *Sample*

   At the beginning of such a study a decision must be made concerning the period of service that the survey is to investigate. In the studies conducted at the Louisville Child Guidance Clinic one year's case load was surveyed. The Detroit Study covered an 18-month period.

2. *Data Sheet*

   The next step is to collect the data necessary for evaluation of the study and for the telephone interview. This can be done most effectively by designing a data sheet which will cover the items pertinent to the study.

3. *Questionnaire*

   A questionnaire must be developed which will contain all the items thought necessary for judging the data collected during the interview. It facilitates the recording of the interview and makes certain that each interview covers the same areas and answers the same questions. The questionnaire also makes it easier to judge each adjustment according to the criteria.

4. *Criteria for Judgments*

   Appropriate criteria should be devised to judge the adjustments of the former clients. A scale based on a revised Witmer Scale (4) was devised for evaluation of the follow-up interview in the Louisville study.

5. *Approach to the Interview*

   "Depth interviewing" techniques should be used to elicit information. The interviewer acts in a more or less catalytic manner, allowing the person being questioned to give information about the adjustment in his own way. Clews to the adjustment are "picked up" by the interviewer and recorded on the questionnaire sheet. This method requires that the interviewer know a great deal about the problems of the individual being questioned and necessitates a careful reading and and recording of information contained in case history of the problem. The interviewer leads the conversation into channels that bring forth information pertinent to the judging data. Familiarity with interview techniques is essential. Other techniques could be developed by the interviewer to meet the needs of his agency and his interest.

PRACTICAL SUGGESTIONS CONCERNING THE CONDUCTING OF TELEPHONE INTERVIEWS

Confidence in the use of telephone as an interviewing tool and experience in the use of this tool has led to the development of certain ideas concerning the actual conducting of a typical interview. Perhaps the best way to describe these concepts would be to tell how such an interview was conducted.

A. *Knowledge of the problem area (preparation).*

Before telephoning, it was deemed essential to have as much knowledge of the case being investigated as possible. The case history was read, the symptoms recorded on the data sheet,

all the information concerning previous contact was noted (i.e., sex, age, number of contacts, names of other members of the family of the patient, etc.)

It was helpful to know the child's nickname or what his family called him, something about his brothers and sisters, the status of his family, etc.

B. *Conducting the interview*

The interview was opened by such a simple statement as: "Is this Mrs. James Smith? Are you the mother of John Allen Smith?" (A specific identifying name is used to assure that the right person was contacted.) "I am Mrs. Bennett of the Child Guidance Clinic. We are doing a follow-up study on some of the patients we saw here five years ago, and we were wondering how Johnny is doing now?" This usually was all that was needed to start the conversation.

The questionnaire sheet was then brought into use. As the mother talked the interviewer noted on the sheet the items that seemed to be answers to pertinent questions. If the desired information about the child did not come forth, it was necessary to resort to direct questioning. Toward the end of the conversation it was useful to elicit some description of the status of the symptom the child had presented five years ago, if possible. Then the mother was asked how she felt about the Clinic and its services. This was recorded verbatim without comment. If she seemed embarrassed, saying, "Do you want my frank opinion?" the answer was, "Yes, the only way we can improve ourselves is to get frank estimates of how our services appear to others."

After the mother was thanked for her co-operation and the child's name mentioned again (expressing the hope that he gets along fine), the conversation ended.

C. *Assessment of adjustment*

An immediate attempt was made to evaluate the mother's responses to the interview. The judgment of the child's adjustment was made while all of the reactions to the interview were still in mind.

The evaluation of the results of the follow-up studies was done by comparing all the interview data with data recorded in the case history. This evaluation has proved of interest in several areas, has pointed up the need of continuing the follow-up research and will, it is hoped, help reveal more areas where the information can be used constructively.

D. *Comparison of results*

Comparison of results obtained by the telephone follow-up study of one agency should be made with a similarly conducted follow-up of another highly regarded agency in the same field. The Louisville Clinic study was patterned after the one done by the Detroit Clinic and the results were compared. This helps judge the results more realistically. It helps answer questions as to how one agency's experience compares with that of another.

ADVANTAGES OF A TELEPHONE FOLLOW-UP INTERVIEW

The advantages of this technique need highlighting so that the telephone interview can take its proper place as a research tool.

1. It is much less time-consuming and costly than face to face interviewing.
2. It affords a larger population for follow-up evaluation in a shorter time.
3. It reduces, in most cases, the embarrassment and resulting hostility that a home visitor might engender.
4. It allows the interviewer to take copious notes without creating anxiety on the part of the client. (The intention is not to prevent the client from knowing that what is being said is being written down, but to insure that the process of note taking

does not intrude and threaten the freedom of conversation.)

5. The *lack* of face to face contact can be of advantage to the interviewer since he can dispense with the social amenities necessary in such contact. Prejudices, distractions by the personal appearance of the interviewer, etc., are avoided in this type of interviewing.
6. A telephone conversation is an accepted way of communication. It demands the attention of those responding to the subject under discussion. The telephone seems to command priority over distractions. Interruption are rare and usually are dealt with speedily.

A study done by Dr. Levitt (3) of Indiana University has given certain criteria for the per cent of cases one can expect to be able to contact in follow-up studies. He has estimated that the per cent of cases which will be interviewed can be represented as a function of the time interval between the close of treatment and the follow-up study.

His estimate is that:

1. A three-year interval will produce 69 per cent $\neq 4.5$ of the total population under study.
2. A four-year interval will produce 64 per cent $\neq 4.5$ of the total population.
3. A five-year interval will produce 59 per cent $\neq 4.5$ of the total population.

The number the author was able to reach by telephone falls within the limits presented by Dr. Levitt, whose estimates were made concerning face to face interviewing.

PROBLEMS OF INTERVIEWING BY TELEPHONING

Several incidents which bear noting occurred during the conversations. The interviewer was asked several times about the psychological tests and their significance. If necessary it was explained that we use these tests as tools to guide us in helping the child and to understand him.

In several instances the mother indicated a need for further help either for the former clinic patient or another member of the family or a neighbor. It was suggested that a conversation with the intake staff member of the Clinic would be helpful to her or that her family physician could tell her what course of action she should take. Referral to private, professional persons was suggested in some cases.

The mother was supported in seeking appropriate help for these problems. In cases where it was felt that she needed support because of her own dependency needs, the suggestion was made that she call the therapist who had worked with her before—providing he was still available—and discuss the problem with him. At times it was necessary to exercise skill to avoid counseling over the telephone.

All questions about the Clinic that were felt appropriate were answered, especially those concerning the follow-up interview. This was described as a continuing interest in the child's future. In all cases of criticism the mother's need to feel the way she did about the Clinic was recognized and the criticism accepted.

LIMITATIONS OF TELEPHONE INTERVIEWING

1. *Subjectivity*

The subjectivity of this kind of interview is, of course, its greatest drawback as a scientifically valid instrument. Case records are equally subjective. However most of the procedures of an agency dealing with services to individuals do not lend themselves to carefully controlled scientific research methods. Gross per-

centages and tabulations of subjective judgments are all such a survey hopes to obtain. More systematic collection and recording of data would assist in this research.

2. *Validity of informant's opinion*

The person interviewed should be one who has the opportunity for close observation of the former patient's problem. In the case of the clinic patients, it seemed obvious that the mother's estimate of the child's adjustment was acceptable as data. It was felt that the mother's opinion of the child's adjustment would be an informed evaluation of the resolution of his problems since she was also treated at the Clinic. The mother's word was accepted, for the most part. Sometimes, however, it was necessary to make a judgment based on clinical knowledge of such a problem, substantiated by data from the interview and from the history of the case. Subjectivity and psychological bias can and do operate in this area.

3. *Check of validity*

A check of the validity of the telephone interview could be made by conducting face to face interviews with a sample of the population under study. As short an interval of time as possible should take place between one interview and the other. In fact the telephone interview might easily be ended with a request for a face to face interview and an appointment arranged at that time. A high level of correlation between the two techniques should not be expected. A validity check is being planned for the follow-up study of the Louisville Child Guidance Clinic. Its results will be prepared for publication when available.

4. *Check of reliability*

A way of judging the reliability of such data and techniques would be to have several interviewers working on interviews at the same time, using the same method. Obviously, they could not reinterview the same people but they could review each other's results on the questionnaire sheets and make independent judgments that could be re-evaluated when they disagreed. Unfortunately such testing of reliability was not done in the investigation at the Louisville Clinic. However a consultant checked every third interview report and verified the judgment made by the interviewer.

THE TELEPHONE IS A USEFUL TOOL IN CONDUCTING FOLLOW-UP INTERVIEWS

An agency may be convinced that an assessment of adjustment after contact might afford an all-over view of the role of that agency in such adjustments. This type of survey makes it possible to extract information that opens up many areas where more intensive investigation could be made. Such an agency may want to assess its work for the purpose of improving its services and meeting the needs of its clients in a dynamic way. The telephone interview, if conducted carefully and wisely, can afford a practical means of accomplishing these ends.

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MARTHA EDENS, B.J.
BERT KRUGER SMITH, M.A.
M. L. RAMSEY, M.A.
C. C. COLLINS, B.A.

What mental health associations can do for families of the mentally ill

What are some of the unmet needs felt by families of the mentally ill? How can the mental health association help fill these needs?

Some answers to these questions were revealed in a recent study conducted by the Texas Association for Mental Health, The Hogg Foundation for Mental Health, and the Board for Texas State Hospitals and Special Schools. Replies on the meticulously prepared questionnaire designed for the study brought the desired and important information, but we felt the revelations in the unsolicited comments were just as important, if not more so.

The primary purpose of the study was to determine which of two methods was most effective in distributing *Mental Illness: A Guide for the Family*, by Edith M. Stern, through the state mental hospitals, how closely that particular booklet came to meeting the needs of Texans who would be reading it, and its effectiveness in increasing their knowledge and understanding of mental illness.

The response of families to the booklet and their eagerness for information about an illness they don't understand and the hospital which offers treatment has implications for mental health associations, whose primary interest is in the improved

Mrs. Edens is Education Services Director for the Texas Association for Mental Health, Austin, Tex.; Mrs. Smith is Head of Mental Health Information Services for The Hogg Foundation for Mental Health at The University of Texas, Austin; Mr. Ramsey is Director of Psychiatric Social Service at Rusk State Hospital, Rusk, Tex.; Mr. Collins is Chief Psychologist, Wichita Falls State Hospital, Wichita Falls, Tex.

care and treatment of the mentally ill and handicapped.

Distribution of *Mental Illness: A Guide for the Family* is a project undertaken by several state and local mental health associations. In most cases the booklet is made available through the state hospitals by asking the hospitals to give all families admitting patients a copy of a letter written and signed by the MHA. A postcard, which the family may mail directly to the MHA to request a copy of the booklet, is attached to the letter. This method leaves the initiative for requesting the booklet with the family.

When it was preparing to embark on this project, the Texas Association for Mental Health wondered if this method should be copied or if the state association should make an effort to see that every family was given a booklet at the hospital. TAMH also hoped to discover whether the 92-page unillustrated booklet was suitable for the large number of persons with little formal education to whom it would be given. The Hogg Foundation for Mental Health was interested in research on individuals being reached by mental health materials and the responses the materials evoked. Combining these interests in one study seemed natural, and the Board for Texas State Hospitals and Special Schools, always interested in volunteer efforts which benefit the mental patient, wholeheartedly agreed to co-operate and assist in the planning.

HOW THE STUDY WAS CONDUCTED

Two hospitals of comparable size and number of admissions per month were selected for the study. Latin-American patients were eliminated from the study because of the language problem. The study also did not include persons hospitalized on criminal court commissions.

Two distribution procedures were alternated in the hospitals. For the first four months a member of the social service department of one hospital handed the booklet to the relative accompanying first-admission patients (Method A) while in the second hospital the social worker gave a form letter and postcard which could be used to request the booklet (Method B). The procedure was reversed for the second four-month period. In both cases, when families were unable to accompany the patient the hospital social service department mailed the letter or booklet to the guardian along with other materials from the hospital.

A month after obtaining the booklet or letter the relative received a questionnaire, designed by the Hogg Foundation staff, which was to be filled out and returned to the hospital. Space was left on the questionnaire for comments. No signature was requested.

Near the end of the study, a control group of 100 was chosen from the city directories of Fort Worth and Houston, two cities served by each of the two hospitals. Only those people listed as heads of families were included. The questionnaire sent with the booklet to this control group was the same as the one mailed to the patients' families, with these exceptions: the explanatory paragraph at the head of the questionnaire was changed in order to be meaningful to this new group of people, and one question was added, asking whether the individual now had, or had ever had, a relative in a mental hospital. If the answer to this query was positive the questionnaire was to be discarded. This decision was made in order to keep the control group as far removed as possible from any personal knowledge of mental illness.

TABLE 1

Responses to booklet as indicated by returned questionnaires

	Number of Letters Handed Out to Relatives	*Number of Booklets Handed Out or Requested by Mail*	*Percentage Returning Follow-up Questionnaire Sent 1 Month Later*
Given Booklet (Method A)			
Rusk (Jan.–April)	...	173	32.0
Wichita Falls (May–Aug.)	...	366	26.2
TOTAL		539	29.1
Given Letter (Method B)			
Rusk (May–Aug.)	250	121	30.5
Wichita Falls (Jan.–April)	308	222	32.8
TOTAL	558	343	31.6

RESULTS

The number of people taking the initiative to send for the booklet after being given the letter was considerably higher in the Wichita Falls Hospital in West Texas than the Rusk Hospital in East Texas, a more rural area. Approximately three out of four persons in the Wichita Falls area sent in the postcard as compared with almost one out of two in Rusk.

During the eight-month period of the project, 882 persons were either given or mailed the booklet. Of this total, nearly one-third (or 262) returned the questionnaire. Using the return of the questionnaire as an indication of response, we found that those who requested the booklet responded in about the same number as those who had been given the booklet. *It seemed fair to conclude therefore that a group confronted by mental illness responds in fair number to a booklet which is meaningful to them, regardless of the distribution method.* (See Table 1.)

Response from the control group, unmotivated by any known interest or connection with mental illness, revealed a startling fact: Of the 100 persons in two cities who received copies of the booklet and the questionnaire, only four returned the questionnaire. Each one of these persons read all of the booklet and each of them stated that he thought that the pamphlet should be very helpful for families of the mentally ill. *The small percentage of this group in comparison to the families of hospitalized patients who responded affirmed a growing theory that a homogeneous, highly motivated group will respond to a mental health education effort in which they have a deep interest, while similar educational efforts are utilized much less by people who have no apparent involvement in this particular topic.*

No great significant statistical difference was found between Method A and Method B in the amount of the booklet read by those who received it at the hospital and those who had to send for it. Of those persons returning the questionnaires, 60 per cent of those who were handed the booklet and 75.5 per cent of

TABLE 2

Differences in amount of booklet read under Method A and Method B

Amount Read	*Relative Handed Booklet (Method A) (N—145 cases)*	*Relative Handed Letter (Method B) (N—95 cases)*	*Differences*[1]
None	19.0%	12.0%	7.0%
One Chapter	21.0%	9.5%	11.5%
2–5 Chapters	25.5%	35.0%	—9.5%
6–10 Chapters	4.0%	6.0%	—2.0%
Entire Booklet	30.5%	37.5%	—7.5%

[1] None of these differences is statistically significant from zero.

those who were handed the letter read two or more chapters of the book. (See Table 2).

In addition to reiterating that the distribution method did not influence the responses from individuals, we felt this information helped to confirm the booklet's readability among the less educated. The grammar, spelling and handwriting on many of the returned questionnaires seemed to us to indicate that several of the booklet's recipients were poorly educated persons, most likely beneath the sixth grade reading level of the booklet. Yet all of us who read through the replies and comments felt that they reflected an understanding of the book's message. *One might observe that highly involved people are willing to dig a little harder and can therefore benefit from materials which might seemingly be above their heads.*

In our opinion the value of the booklet to the family was again confirmed by the number passing their copies on to others. Although 16 per cent of the questionnaires had no answers on who had read the booklet, other replies showed that 42 per cent of those persons returning questionnaires had given the booklet to relatives to read; 14 per cent had given it to friends, and 28 per cent had given it to no one.

Asked to indicate which chapters in the guide they felt most helpful, about one in eight persons complied. Three chapters received heavy preference: "The Hospital World," "Letters and Visits" and "When the Patient Comes Home." The other five marked were the first three chapters pertaining to mental illness and the need for hospitalization and two others giving information about treatment and family-hospital relationships. An insignificant number replied to the question about chapters which were not helpful.

Although 50 per cent of the questionnaires brought answers to the question "In your opinion, was the booklet easy to read?" it is debatable how valuable the answers might be. All replied "yes," and one is inclined to wonder if a person would be reluctant to answer otherwise.

Two interesting sidelights were the revelations that more fathers than mothers returned questionnaires and made unsolicited comments (and likewise more husbands than wives) and that proportionately more Negroes than Anglo-Americans returned questionnaires, although they offered fewer spontaneous comments.

FAMILIES' NEEDS EXPRESSED

Asked what else they thought ought to be made available to relatives of patients in the way of services, explanation or assistance, more than half of the persons replying made comments. The most poignant one, perhaps, was made by one relative who scrawled his answer to the question in an almost illegible hand across the questionnaire: "kindness."

The questions and needs expressed fell into four major areas: the family's relationship with the hospital, the family's relationship with the patient and other members of the family, the need for more information about hospital rules and regulations and the need for more information about the illness befalling the family member who has been hospitalized. Although some of the services desired are obviously the prime responsibility of the hospital and will doubtless begin to be provided by them as staff and time allow, those of us who had participated in this study recognized that these services were an improbability at this point. Yet, being both impressed and perturbed by the many troubled comments, we were anxious to see these needs met in some way.

This led to our recognition of the role of the voluntary health organization in America today, and to the mental health association in particular. With the improved care and treatment of the mentally ill and handicapped as one of its major objectives, the MHA is a most logical group to become involved. Our experience with the purpose and program of the mental health association led us to believe that many of the needs could be cared for by imaginative mental health associations. Even the lack of some services because of hospital staff shortages has its implication for the MHA, which can contribute to the alleviation of this problem by participation in the Mental Health Careers program. Therefore we feel that this study has significance for MHA programming.

FAMILY RELATIONSHIPS WITH HOSPITAL

The greatest number of family comments concerned the wish for more communication with the hospital and ranged from suggestions for printed monthly forms reporting on the progress of the patient to the desire to talk personally with the patient's doctor each month. One of every four comments expressed a desire for some information about the patient's diagnosis and treatment. As one correspondent said, "If we go to a doctor or hospital we want to know what is the trouble as well as receive the treatment." Families repeatedly asked for "an informational correspondence service;" "a copy of the doctor's diagnosis so that I could more thoroughly understand just what has taken place;" "information on the condition of the patient at regular intervals." One noted wistfully, "I know it would be expensive and time-consuming but I feel sure all relatives would appreciate periodic progress reports on patients."

What an MHA could do: Recruit volunteers to serve as administrative aides for hospital staff in order to provide informational correspondence service.

FAMILY RELATIONSHPS WITH PATIENT AND OTHER MEMBERS OF THE FAMILY

Families expressed concern that nonaggressive patients often had to be taken to the hospital by the sheriff. They had questions about how to converse with the patient; how he could be prepared for his

first visit from them and how the family should respond; how the patient would feel when he realized where he was; why the patient turned against his loved ones and whether he would ever understand and accept them again; how they could prepare for the patient's return; how a setback could be prevented.

Several families requested information on activities in which patients and family members could participate together—family discussion groups and social centers for the returned patient.

One queried: "How do we tell children in the family? As I left your hospital on that sad day I felt so lost, so alone, so brokenhearted. Yes, life seemed so futile without my mother. After having read *A Guide for the Family,* along with living close to God, I have renewed strength and find that life is getting better. This great adjustment is not an easy thing. From time to time I reread chapters in your book and always find comfort in so doing. This fine book reminds me of a little poem; in fact, it often gives me the answer:

> There's always someone needing aid;
> Some trembling heart alone, afraid;
> Some load that could be lighter made."

What an MHA could do: Provide transportation service to the hospital for patients whose families cannot take them. Sponsor a transportation service or bus on a periodic schedule so that families could visit the hospital. If there are few or no family members in the MHA area, set up a transportation fund which could be used by families otherwise unable to afford a trip to the hospital.

Sponsor a monthly (or periodic) Family Day and recruit volunteers to provide several activities and programs in which families and patients could participate together. Provide volunteers to write letters for patients.

Utilize the services of hospital staff people, or professional persons in the community who are trained by the hospital staff, in sponsoring or making possible discussion groups for families with patients in the hospital and/or families whose patients are about to return home. Prepare community employers for the returning patient and provide patients with information about available jobs and assistance in seeking employment. Sponsor or assure social activities for the ex-patient, if warranted in the community.

NEED FOR INFORMATION ABOUT HOSPITAL

Irritations resulting from a lack of communication about small details concerning hospital visits and protocol were mentioned by several families. Such irritations included misunderstandings about visiting hours, appropriate gifts, and miscellaneous other "do's and don't's." Questions about letter writing were raised.

What an MHA could do: Some mental health associations have already offered to produce—for their respective hospitals—a small booklet including pertinent things families should know about the institution and its rules. Hospital budgets rarely cover items like this, important as all may realize they could be, and an MHA could surely be of service here.

NEED FOR INFORMATION ABOUT ILLNESS

Brief information on mental illnesses in *Mental Illness: A Guide for the Family* did not seem to satisfy some families. They had these unanswered questions: "Is it inherited? Can we ever know the cause? How long will treatment be? What is electric shock really like? What could I have done

differently that would have prevented this? Alcoholics aren't mentally ill, are they?"

The social workers who talked with some families found it necessary to relieve their feelings of guilt.

What an MHA can do: Recognizing that it is only second best to a good long talk with the doctor (which is often impossible), MHA's could see that acceptable printed materials on mental illness are available to the families. Supply a reading rack in the family waiting room with material to be read there. Stock a supply of appropriate materials for sale at the visitor's desk. (One chapter provided the initial supply of pamphlets; the hospital volunteers were responsible for the sale rack at the visitor's desk and repurchased materials with the proceeds from the sale of the original supply.) Insert lists of materials on mental illness in copies of *A Guide for the Family.* Provide sample copies of all available pamphlets to the hospital staff since they may be unaware of their existence.

ROLE OF PRINTED MATERIALS IN REASSURING FAMILIES

In the absence of manpower for the ideal kind of communication, printed materials have a real role in providing information and reassurance to the families of the mentally ill. This was reflected in the questionnaires. Many wrote: "I wish we could have had this booklet earlier." "The book helps greatly to console and guide the family of mentally ill relatives." "I couldn't have made it without the advice and help and understanding of this book."

Mental health associations would do well, according to this information, to make every effort to advise ministers, doctors, psychiatrists and family service agencies of the existence of booklets like *Mental Illness: A Guide for the Family* and *When a Parent is Mentally Ill: What to Tell Your Child.* Some MHA's have placed copies with these persons, and with the county judge or whatever legal authority is responsible for court commitment of the mental patient.

Texas hospital superintendents—all hospitals except one now make it available to families of their patients—have been enthusiastic about *Mental Illness: A Guide for the Family.* They report: "The relatives seem eager for information and appear to appreciate having the opportunity to receive printed information . . ." "Many of our families have commented to the caseworkers about the value of [the book] and how it has cleared up many of their questions." "We noticed that they [recipients of the booklet] had a far clearer understanding of our patients, of the illness of their relatives and of what their duties would be in the future. . . . On the whole we think a better understanding was developed between relatives and our entire staff here."

SUMMARY

An eight-month study of the effectiveness of two means of distributing *Mental Illness: A Guide for the Family* by Edith M. Stern through two Texas state mental hospitals brought this information: During the study, 539 booklets were given directly to the relatives of the patients and 343 out of 558 (61.6 per cent) sent in postcards to the state MHA requesting the booklet in response to a letter given to them at the time of their relative's hospitalization. Of the 882 who received the booklet by both methods, nearly one-third (262) returned a questionnaire sent one month after a member of their family had been hospitalized. In contrast, completed questionnaires came from only 4 per cent of the 100 people, with no known mentally ill rela-

tives, who had received the booklet and questionnaire. This seemed to indicate the interest in and response to a mental health publication is far greater when it is pertinent to an individual's current needs.

No significant statistical difference was found in the effectiveness of the booklet as a result of the method of distribution.

The value of a booklet such as this was confirmed by the number of copies passed on for others to read. Specific information needed by the families was demonstrated by the chapters of the booklet which were marked as "most helpful."

The outstanding significance of the study can be a help to mental health associations in understanding their role in spreading understanding of mental illness, lightening the load for the families of the mentally ill, and supporting the hospital's task of care and treatment through an imaginative MHA program.

NORMA PARENT, M.A.

An echo in education

As a senior faculty member in the nation's public school system, I see teaching as one of the most complicated of all professions. Curriculum revision, innovations of method, shifts in philosophy, administrative pressures and the public inquisition are all a part of the job. They are experiences common to years of work in education. Some are pitfalls and anxieties of those who teach. Others are joys of a career.

Growing out of these years of change comes a knowledge about the nature of the human organism. On the basis of this knowledge a person must create a philosophy of facing life's situations with attitudes and beliefs that will modify and control his behavior. An educator, on both public school and university levels, has to achieve a resilient, productive and socially sensitive personality or he will be tempted to toss in the sponge, reject himself as a scholar and the world of learning which was once so delightful to him.

Yet ironically enough nearly every American man or woman who emerges from our institutions of higher learning and plans to make education his life's work dreams of becoming a top-flight teacher. He aspires to make this country a better place for citizens of the world. He feels that his influence is strong. He is confident of his ability and he knows he will be successful. He is sure that teaching is essentially a job of helping students grow into happy, self-directed people who manage their own affairs effectively, get along with their families and neighbors and develop useful skills, industrious habits and clear understandings.

Mrs. Parent, a teacher in the Grosse Point, Mich., public schools for 12 years, is doing doctoral study at Wayne State University in Detroit in evaluation of educational supervision and administration. George Barahal, Ph.D., Professor of Education and Clinical Psychology at Wayne State University, was the educational consultant for this article.

Why have so many with these ambitions left the field of education? How have doubt, mistrust and oppression destroyed the vision of our dream?

A BOMBED VISION OF HOPE

Destruction may not have happened overnight but there are experiences of occupational hazards in social gatherings, from which no teacher can escape.

I was once a dinner guest at the home of a friend. It was a lovely dinner party. The cocktails slipped down gently; the soup was served and the relishes appeared. Then it came. A medical doctor on my left had been talking about the speech he made in Chicago last week. He cleared his throat impressively and said, "You don't mind my asking you a question about my little girl's long division, do you?" Before I could refuse, he continued, "I know this isn't the place but she's having a lot of trouble with that fat woman and everyone says you're such a good teacher and so obliging."

Later on during the same dinner the attractive young woman on my right dodged the hors d'oeuvres and asked hopefully, "What do you think about so-called 'underage' children starting kindergarten? My little boy won't be five until February. He seems quite advanced for his age. Will he have difficulty with reading in the first grade? My, I hope he has a good teacher." Perhaps I was supposed to know the potential ability of the little kid by looking into the mother's soft brown eyes but I didn't, so I listened.

There is no safe place for a teacher. Symptoms of educational diseases can be trotted out anywhere at any time. It might be difficult in a social gathering or in a public place to display a sore tonsil or an infested appendix for free medical service but difficulties with noon playground supervision, interpretation of report cards, the role of the visiting teacher and arguments of how teachers should spend their planning periods surpass all barriers.

A short while ago I was returning from New York. In the club car people were elaborating on their solutions for better prize fights and football games. Suddenly a woman near the window perked up and shot me a glance that meant trouble.

"Tell me! Is it true?" she asked, "that teachers can't read and write English in college classes? There is an article in a current magazine by a college professor who says he's found them almost illiterate."

"The professor must have had some evidence for what he printed," I concluded and turned my attention to the bar.

These tales are not exaggerated. Yet I have not been strictly honest. Teachers love being complimented. We like to be asked information. We know any advice is seldom followed but we have a glow of pleasure when it's requested.

Educators are not the only professional people who suffer from the same onslaught by the general public or share its gratifications. There are many human beings who cannot resist tapping every professional expert for information, but these are friendly social annoyances. There are others, those that infringe upon one's home, his personal life and the dignity of his training. A series of mistrustful challenges such as those described below may have eroding effects on even the most accomplished teacher:

It was Saturday morning about eleven-thirty; I was scrubbing the kitchen floor. The telephone rang impatiently. With rubber gloves and an abundance of scrubbing suds I unsuspectingly lifted the receiver and said, "Good morning, this is the Parents' residence."

An irritated, highly authoritative voice

announced, "I am Mr. X and I called you to find out why you gave my son, Ned, a 'B' instead of an 'A' in reading. He is a straight 'A' student and I want him to continue this record throughout his education." (Ned was then in the second grade.) "His mother and I are very unhappy because of this unjust mark. He has done nothing but cry since he has received his report card. Mrs. X and I should like to have you change this mark on Monday morning."

Professionally speaking I was caught completely off guard and responded defensively, "I did not *give* Ned any mark. The marks which I have recorded on his report card are measures of his growth and achievement in certain areas. If I have made a mistake in recording the measure I shall be glad to correct the error. Right now, as you know, I am at home. I have no classbooks nor any materials with which to qualify any marks. I think that it is your job as a parent to help Ned recognize his limitations. If you yourself could accept something less than perfection from him, both you and he might be happier."

My blunt, unasked-for analysis had anything but a soothing effect on Mr. X who ended the conversation with, "I shall expect an accurate, detailed account of why my boy got that 'B.' If the mark is not changed I shall take the matter up with *your* principal. Good-by." BANG!

"Ulcer gulch!" I muttered as I resumed my Saturday's scrubbing. "I don't get paid for that, nor a few other things that come with teaching. I thought of a Pete I had taught once upon a time.

Pete was in the second grade. He was mentally slow but in the regular grade. He as yet could not write and read very little. He was a pompous youngster and told elaborate stories about his experiences but was well-liked by the children in the room. I thought he was apparently pretty well-adjusted socially until one morning when he was returning from class, he went to the table of another child, Jerry, who was studying, and expectorated in his face.

Jerry, who was a superior student and perhaps one of Pete's closest playground friends, cried out. The froth and slime and nasal mucus dripped from his surprised countenance. Quite frankly I shared his hurt feeling. One can understand that Pete must have had some hateful feelings of inferiority, that he wasn't happy with himself and that he needed help, but another child must not be made the victim of such attacks.

Jerry washed his face. When I talked with Pete he seemed to be sorry but said he did not know why he had done it except that he had a mouthful of "spit." When I mentioned this in a conference with the parents, they were angry at what they called my apparent lack of disciplinary control. The father explained, "I have my own machine shop and I am far too busy with that to get involved with a trifling matter like this when it's your problem not mine. You should have given Pete a good thrashing for a trick like that. That would have straightened him out. He needs one every day or so anyway. There is your answer. He'd never get away with that with me."

Mama reinforced papa's analysis. That's exactly right. Whenever he spits or even puckers up as though he's going to, I get the strap I always have hanging in the bathroom and strap him on his bare bottom until he can't forget it. That is what you should do instead of bothering us. You ought to get fired for not doing your job."

As I reminisced over my Saturday's scrubbing I set my teeth, "An educational sociologist would have suggested that during this unpleasant conference I should have busied

myself making an accurate written record of all the parents had said. It might have had a cooling effect on them, but how thick should my skin be?"

In that self-pitying moment my memory turned to the after school schedule of the following week. Monday night there was a P.T.A. from 7:30 P.M. until ten or eleven o'clock, depending on the long-windedness of the organization's president, his second lieutenants and the evening's speaker.

Tuesday night we would have our weekly faculty meeting, a professional gathering of the building staff, where announcements are made, free, open discussion surely not encouraged and little ever accomplished. The meetings were a "must" on our calendar.

Wednesday: A philosophy workshop that lasted until 5:30 P.M. at the board office.

Thursday night: A Wayne University class in educational statistics.

On Friday, after 3:30 P.M., would I have time to intelligently organize my lesson plans for creative teaching, carefully study the silent reading work of my 32 children and prepare materials for those who needed additional help, manuscript an experience chart for the science class and see Mr. Price, a parent who had asked for a conference at five o'clock Friday afternoon?

"Time!" I laughed. Carl Sandburg has said, "Time is a sandpile we run our fingers in. It is high enough to last a lifetime, through, and big enough to build many castles. If we spend too much of it fretting over day-by-day tactics we probably won't get half as much done or half as much fun out of doing it as we will if we concentrate on the grand strategy of disposing our share of eternity." [1]

[1] *See* Dimnet, Ernest, *The Arts of Living* (New York: Simon and Schuster, 1954), in chapter on "The Art of Balancing Time" by Charles Poore, p. 116.

THINGS GOOD TO REMEMBER

Time can be used more than once, particularly through memory. The suds from my Saturday's scrubbing ceased to foam so wildly. I relaxed, stripped off my rubber gloves and forgot the frustrating anxieties of these isolated incidents, only to remember the rewarding relationships I have had with children in the public schools.

One autumn day after World War II, I came to the desk of a child who was one of many displaced persons. He was working on a picture painted in colors of gold and silver. My eyes were compelled to follow the dainty filigree of fascinating images. As I watched, his fingers fashioned the wildlife of his native woods combined with the brilliant colors of our Midwestern autumn trees. When the picture was finished he brought it to me for the bulletin board. I asked him if he wanted to take it home after it had been exhibited. He shook his thin countenance sadly and answered, "No, I have no mother."

Then there's the boy who explained hibernation in this manner: "Hibernation means a long comfortable sleep. A caterpillar spins his cocoon and sleeps. His cocoon is his nice warm bed made with nature's electric blanket."

There's a joy in discovery of the great variety of patterns in which children are created. They differ more than in shapes, size and color. It is fun to hear, see and feel the individuality of their growth. A child is part of the order of nature as much as the stars, the streams, the flowers. He obeys laws of growth that are as irresistible as those that govern the planets in their courses. We cannot teach him to grow. We cannot say that on this day or this month or this year he will learn to write certain numbers, to borrow in subtraction, to repeat a multiplication table. An absolute

approach will lead us into error. We must think in terms of relative forms. There is a theme or tempo of growth which determines the way a child will meet the problems of growth. Before a child makes the organizations which give meanings to symbols, he must make the journey. It is when the journey is zestful that children make their ordered, logical arrangements. Then it is that they find delight in manipulating symbols and get satisfaction in those unities of quantity and space that are a part of abstractions. They begin to feel the power and strength of accuracy and design.

HOW DO WE UNDERSTAND?

In order to have an insight into the child's problems and the issues with which he is coping, the teacher must strive to face the same issues within his own life. These issues are largely emotional in nature. To understand oneself and others has a deep emotional significance. It calls for more than intellectual cleverness and academic competence.

To appreciate another's feelings one must seek to recognize and understand one's own. To be able to sympathize with the child who is hostile (and all children are, more or less) the teacher must face his own hostile tendencies and try to accept the implication of his anger as it occurs, say, in his annoyance with his pupils, his impatience with himself, his feuds with other teachers, his complaints against parents or school authorities or others on whom he fixes his ire.

He must be prepared to examine and seek to realize the significance of his feelings of being abused and his devices for avoiding responsibility for himself by blaming others. The more a person can face some of the ramifications of his own anger and make some allowance for his tendency to become angry, the more sensitive he can be to the hurts, frustrations and anxieties involved in another person's anger.

Similarly, to realize the turmoil another is undergoing, a person must try to examine his own defenses. To do so may be more painful and threatening at the moment than to keep pretending these defenses don't exist, but unless he can seek to fathom his fears as they appear in his phobias, squeamishness, fear of misfortune, timidity, uncertainties, fear of making mistakes and fear of what others may think of him, his ability to perceive that others are frightened will be quite limited.

Unless a person is prepared to take at least a little note of his own anxieties, he is likely to be uncomprehending when children helplessly express theirs. He may even be harsh when children's anxieties break through in such signs as inability to learn, unwillingness to try for fear of making mistakes, impertinence, inattentiveness, restlessness, irritability, unreasonableness and countless other symptoms which indicate that a child is uneasy and at odds with himself.

A person's wisdom as he looks outward upon others can only be as deep as the wisdom he possesses as he looks inward upon himself. The farther a teacher goes in understanding himself and others the more deeply he can realize the common humanity he shares with others, even with those whom he dislikes. The more genuinely he is involved in his own struggle to understand and to face the problems of life the more he can realize this kinship with others, whether they be younger or older or like him on unlike him in education, wealth, race, religion, social status or professional rank.

How does one achieve understanding of self? This is a crucial question in the preparation of teachers. It cannot be ans-

wered by the usual courses of study, methods and lesson plans in our teacher-education programs. These may be valuable for other purposes but knowledge of self requires a different kind of personal involvement than the usual academic course encourages or demands. One broad principle is this: To gain in knowledge of self, one must have the courage to seek it and the humility to accept what one may find. If we have such courage and humility we might be on the road to finding better answers for these questions!

How far is it to the nearest star?
A million miles or so?
How far is it to the yellow moon?
Oh there I'd love to go!
How far is it to the big round sun
That sets your eyes aglow?
How far is it to the big blue sky?
Those answers I'd love to know.
How far does the strong wind go,
When I hear it whirl and roar?
How far is it to those puffy clouds
And how far to Heaven's door?

—Judith Allison, age ten.

EVA DEYKIN, M.S.W.

The reintegration of the chronic schizophrenic patient discharged to his family and community as perceived by the family

It has been stated that with every passing year of hospitalization the chronic schizophrenic's chances for rehabilitation and readjustment to the outside community become lessened.[1] It is also felt that not only is the patient's capacity for readjustment lessened after a long period of hospitalization but also the family's availability to and interest in the patient tends to diminish in time, making the possibility of rehabilitating the patient even more difficult.[2]

This paper is part of a study on the relative effectiveness of drugs and social therapies in two milieux: in a custodial setting and in an acute treatment center. Sixty chronic schizophrenic patients who had been hospitalized continuously for five years or more at either the Metropolitan State Hospital or at the Boston State Hospital (both are primarily custodial settings) were transferred to the Massachusetts Mental Health Center, an acute treatment hospital, for a period of either six months or one year.[3] Any or all of the social therapies given at the Massachusetts Mental Health

Mrs. Deykin is a Psychiatric Social Worker at the Massachusetts Mental Health Center, Boston, Mass. This investigation was supported by a research grant from the National Institute of Mental Health.

[1] Morgan, Norman C. and Nelson A. Johnson, "Failure in Psychiatry: The Chronic Hospital Patient," *American Journal of Psychiatry*, 113(March, 1957), 824–30.

[2] Webb, K., *The Social Service Experience on the Pilot Study*, an unpublished report. (Sacramento, Calif.: Stockton State Hospital, California State Department of Mental Hygiene.)

[3] The original design of the study stipulated that the patients were to have stayed at the Massachusetts Mental Health Center only six months. However, in accordance with a subsequent modification of the research design, 16 patients who were not given drugs during the first six months were started on drugs and kept at the Center an additional six months.

Center were made available to this group of 60 patients. These social therapies included psychotherapy, social casework, occupational therapy and group therapy. The type of social therapy any individual patient received was left to the discretion and judgment of the patient's resident doctor. Thirty patients in this group of 60 were also given drugs.[4] An additional group of 60 patients, comprising the control group for this study, remained at the Metropolitan State Hospital and at the Boston State Hospital. Thirty patients in the control group were also given drugs according to the established formula.

It is noteworthy that in spite of severe chronicity, extreme regression and, in some cases, lack of close family ties, 14 of the 60 patients who were transferred to the Massachusetts Mental Health Center (over 23 per cent) were discharged to the community. A follow-up study has been completed on 13 of these 14 discharged patients.[5]

The purpose of the follow-up study was to evaluate: (1) what level of social adjustment was attained by the patients subsequent to their hospital discharge and (2) whether the level of adjustment attained justified the hospital discharge. In order to gain this information, the families and/or informants of the patients were interviewed by a social worker some time after the patient's discharge from the Massachusetts Mental Health Center. At the time of the follow-up interview with the families or informants, eight patients had been discharged a year or more, and five patients had been discharged three months.[6] These two groups of patients will be discussed separately for it would be unrealistic to compare the readjustments attained by a patient who had been in the community one year or more with that attained by a patient who had been out of the hospital only three months.

The sample consisted of 13 patients, nine females and four males. All of these patients had a diagnosis of chronic schizophrenia and had been hospitalized at least five years continuously at Metropolitan State Hospital or at Boston State Hospital before being transferred to the Massachusetts Mental Health Center. All these patients received either social casework or psychotherapy while they were at the Massachusetts Mental Health Center, and in nine cases the families of these patients were seen in intensive casework by a social worker.[7]

The focus of casework was discharge planning for the patient. With the exception of one patient, all had been taking drugs at some point of their hospitalization.[8]

At the time of the follow-up eight patients were living at home with members of their families; three were living at the Half-

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[4] *Male Patients:* Chlorpromazine 100 mg. t.i.d.p.c.
Reserpine 1.0 mg. t.i.d.p.c.
Trihexiphenidyl 5.0 mg. t.i.d.p.c.
Female Patients: Chlorpromazine 50 mg. t.i.d.p.c.
Reserpine 0.5 mg. t.i.d.p.c.
Trihexiphenidyl 2.5 mg. t.i.d.p.c.

[5] One patient died shortly after discharge, before any follow-up could be done.

[6] It was hoped that all follow-up interviews with the families or informants could be done at least one year after the patient's discharge. Because of a time limitation five families or informants were interviewed when the patients had been out only three months.

[7] Paper is in process on social casework in relation to discharge.

[8] Seven patients were put on drugs immediately upon admission to the Massachusetts Mental Health Center in accordance with the original design of the study; two patients were no-drug patients for six months and were then put on drugs for another six months according to the modification of the original design. One patient was to have been a no-drug patient but, because of severe assaultiveness, was put on drugs shortly after admission. One patient was a no-drug patient and remained so throughout his hospitalization.

CHART I

Adjustment of patients discharged at least one year

Patient	*Description of Patient*	*Social Functioning*	*Interpersonal Relationships*	*Total Level of Adjustment*
Miss A.	Excellent in all items.	Excellent in all items.	Excellent in all items.	Excellent.
Mr. B.	Excellent in all items.	Excellent in terms of responsibility for self and others but moderate in social life and independence. No employment.	Good in most areas but is still somewhat withdrawn.	Good.
Miss O.	Good in all items except for judgment which is sometimes poor.	Excellent except for employment and independent social life.	Good in most items; still tends to be somewhat withdrawn.	Good.
Miss D.	Good in all items except for judgment.	Excellent in all items except for social life and employment.	Good in all areas; is fairly sociable and involved with family.	Good.
Miss P.	Good in appearance, fluctuating in mood, stream of speech and mental content.	Good in social functioning; social life and employment lacking.	Withdrawn but not hostile, a good follower.	Good.
Miss F.	Good in appearance; fair in psychiatric terms.	Responsibility for self is good. Socially totally inactive. No employment.	Interaction is only fair; tends to be hostile at times for no apparent reason.	Limited.
Miss G.	Good personal appearance, poor and deficient in all psychiatric items.	Good responsibility for self, totally deficient in all other items.	Very poor in all items. Patient is hostile, unable to get along with anyone.	Limited.
Mr. H.	Unkempt, careless appearance. Judgment very poor; moderate adjustment in other items.	No responsibility for self and others. No social life or employment.	Extremely limited interaction; difficult to involve him in any activity.	Poor.

Way House; [9] one was living by herself in a rooming house; and one was living at a nursing home where she was employed as a nurse's aide.

The criteria for the social adjustment of the patient are defined in three main areas:

1) Description of the patient, which includes his personal appearance, his stream of speech, his mental content, his judgment and his mood;

2) The social functioning of the patient, which includes his social life, his capacity to assume responsibility for himself and others, and his employment, if any;

3) The patient's relationship to his family and community, which includes the degree of the patient's involvement and interaction

[9] Rutland Corner House in Boston, a residence for formerly hospitalized female mental patients.

CHART II

Patients discharged three months

Patient	*Description of Patient*	*Social Functioning*	*Interpersonal Relationships*	*Total Level of Adjustment*
Miss K.	Good appearance. Good in psychiatric items.	Responsibility for self and others good. Social life limited to what family does. No employment.	Interacts well and eagerly with family. Is not withdrawn except in new and strange situations.	Good.
Mr. M.	Good in appearance. Good in all psychiatric items.	Complete responsibility for self-care. Assumes some responsibility in home. Does small chores and errands. Social life consists primarily of family activities. No employment.	Active interaction with family and neighbors. Has made a few new friends. Tends not to initiate activities but is a willing participant in almost all planned activities.	Good.
Miss W.	Fairly good in appearance. Good in all psychiatric items.	Responsible for self-care. Assumes some responsibility for cooking, cleaning, tidying the house. No social life of her own. No employment.	Somewhat withdrawn with unfamiliar people, but interacts well with family. Generally joins in family activities.	Good.
Mr. J.	Very poor in appearance. Psychiatric items fair.	No responsibility for self or others. Social life very limited. No employment.	Very withdrawn. Will not become involved with family activities.	Limited.
Miss I.	Very poor in appearance. Very poor in all psychiatric items.	Very poor adjustment in all items. Had a job but was not functioning well in it.	Very hostile; acted out. Did not get along well with either employer or fellow workers.	Poor.

with his family, the extent of the patient's contacts with agencies and resources in the community and the family's tolerance for and expectations of the patient.

The level of the patient's total adjustment is determined by the "score" he received in each of the three areas mentioned above. It was found that several patients whose personal appearance, mental content, stream of speech, affect, judgment and mood were all good had not actually attained a good adjustment because of failings in the other two areas. A detailed examination of individual patients appears in Charts I and II.

A patient is said to have attained "excellent" adjustment when he receives the maximum score in each item of all three areas. Gainful employment is necessary in order to attain a rating of "excellent" adjustment. "Good" adjustment is seen in patients who have maximum scores in the majority of

items in the three areas and who show ongoing improvement in other items. The term "limited" adjustment is reserved for patients whose actual adjustment or post-hospital improvement is poor, but who show potential for and promise of further improvement. "Poor" adjustment applies to those patients whose potential for further improvement seems poor and whose actual improvement and adjustment is very minor. Patients with poor adjustment have gross failings in each of the three areas.

Examining the group as a whole it was found that of the eight patients who had been in the community a year or more, only one had attained an excellent level of adjustment; four had attained good adjustment; two had limited adjustment; and one had poor adjustment. Of the five patients who had been discharged only three months from the Massachusetts Mental Health Center (at the time of the interview with the families and/or informants) three had attained good adjustment; one had limited adjustment; and one had poor adjustment.

CASE EXAMPLES—ONE YEAR FOLLOW-UP

Excellent Adjustment

Miss A., who had excellent adjustment, is described by Miss Z., the head of the Half-Way House, as being a neat, clean, well-groomed person who was coherent and relevant in her speech and who consistently exhibited good judgment. Miss Z. stated that Miss A. was employed as a scrubwoman, and that she was working five hours a day. The patient took complete responsibility for getting to work on time and for notifying her employer when she was unable to get to work. She was financially independent and budgeted her money in such a way as to be able to save small amounts. Miss Z. reported that Miss A. was cheerful and well-liked by the other women at the Half-Way House. At first Miss A. did not socialize too well at the Half-Way House. Miss Z. felt that this was due partly to Miss A.'s initial withdrawal and partly to her evening working hours which made it difficult for her to meet and get to know the other women who, for the most part, had daytime jobs. In time, however, Miss A. did make friends at the Half-Way House although she did not rely on them completely for her social life. Instead she frequently made her own plans and on several occasions spent the week ends visiting relatives in the Greater Boston area or in New York. At the time Miss Z. was interviewed, Miss A. was in the process of looking for her own apartment for she wanted to move out of the Half-Way House. Miss Z. felt that this was a feasible plan as Miss A.'s ability to be self-supporting, her social life and her good relationship with her family were all signs that she was capable of taking such a step.

Good Adjustment Level

The statements of four informants, whose patients had been discharged one year, revealed that their patients had reached a good level of adjustment and showed signs of continuing their improvement. Three of these patients were living with their families and one was living at the Half-Way House.

None of these patients was employed in the community. Two patients, as part of their day hospital programs, assisted employees at the M.M.H.C. One worked several hours a day in the coffee shop, and the other assisted in the linen room. All four patients were described by their informants as being neat, clean and appropriately dressed; they did not openly manifest

any overt psychotic symptomatology although one patient was reported as being deluded from time to time. For the most part, these patients had good grasp and judgment. All of these patients assumed complete responsibility for their personal needs. They bathed and changed their clothes without being told; they kept appointments faithfully and assumed responsibility for taking their medication. These patients also assumed some degree of responsibility in the home. Two informants stated that the patients would help with the housework and could be trusted to do some cooking and marketing. The other two informants stated that their patients took care of their personal belongings and their rooms but did little else in the house.

The area in which patients with good adjustment had the greatest difficulty was the area of interpersonal relationships. None of the four patients had his own social life. They were still quite withdrawn and would rarely initiate an activity or conversation although they all participated in their families' social activities to a large degree when they were invited to do so. All of these informants stated that they were pleased with the progress the patients had made and some were, in fact, surprised that the patients' improvement had been so great. None of the informants felt that it was necessary for the patients to get a job immediately although they stated that they hoped, in time, the patients would be able to become gainfully employed.

It was noted that these informants were realistic about the degree of the patients' improvement and did not try to push the patients beyond what they realistically were able to do. It is interesting that these informants were extremely optimistic regarding the eventual prognosis of the patients, and that they stated that the patients were showing enough improvement week by week to make them think that eventually the patients would be completely rehabilitated. Because of the encouragement these informants received from seeing the slow but constant improvement in the patients, they usually had high tolerance for any abnormal behavior in the patients. Even minor relapses were accepted and interpreted by the informants as being "par for the course."

A representative example of patients with good adjustment is Mr. B., who a year after discharge was working in the Massachusetts Mental Health Center linen room as part of the day hospital program. He came to work faithfully and did competent work with only minor supervision. His sister reported that at home he was quiet and somewhat withdrawn but that he got along well with other family members. He helped with the housework and seemed to take a great deal of pride in the neatness and cleanliness of the home. His sister stated that one day when her mother had just finished waxing the floor, someone walked in with muddy boots, leaving dirty puddles on the floor. When the visitor left, the patient got a mop and cleaned the soiled area.

Mr. B.'s social life, like that of all patients in this group, is limited in that he participates in his family's plans but does not initiate his own activities. Actually, Mr. B. is more socially active than most patients in this group because his family is more socially active than most. His family frequently goes on outings, to football games, to the movies and to visit friends and relatives. The family encourages Mr. B. to join in all of these activities and has successfully involved Mr. B. in the family social life.

Miss D., another patient who also has attained a good level of adjustment, has a much less active and varied social life. She lives alone with her aged mother. In this family, the social life consists primarily in

attending church suppers or going to an occasional lodge meeting. While Mr. B. and Miss D. have different kinds of social lives, both have adopted well to their families' normal activities and thus, relatively speaking, both have adjusted to the same satisfactory degree. Miss D., like Mr. B., does not initiate activities but is a willing follower. The amount of social life and exposure to the community a patient in this group will have is dictated by the degree of outward orientation his family has.

Limited Adjustment Level

There were two patients who, after having been in the community one year, had made limited adjustments to their families and community. These patients show failings in each of the three major areas. According to the informants, they consistently show abnormalities of speech or thought processes. Both patients have some defects in their judgment and grasp. On the other hand, they have been able to function sufficiently well so that their families did not feel it was necessary to rehospitalize them.

Miss G., one of the two patients in this group, lives alone in a rooming house in Roxbury, Mass. Her social worker, who was the informant because no family was available, reported that even though the patient was still actively paranoid, she was able to care for her room, to dress attractively and to budget the money she received from Disability Assistance in an intelligent manner. Miss G.'s interaction with other people was very limited; she tended to be hostile and withdrawn. Between the time of her hospital discharge and the time of the follow-up interview with her social worker, she held a job as a switchboard operator but had to be fired after a brief period because of her inability to get along with her fellow workers. Miss G.'s social worker stated that she felt Miss G. might improve because she was beginning to talk more freely in the casework situation.

Miss F., the second patient in the limited group, also had great difficulties in interpersonal relationships. She lived with her family but would rarely join in the family activities. Her family reported that she often would have outbursts of temper in which she would accuse some member of the family of having been unjust to her. These outbursts were followed by periods of sulkiness; the patient would retire to her room and refuse to come out. Despite this behavior, the family felt that the patient was improving because she recently had had fewer outbursts and was doing well in her work at the coffee shop.

At the time the follow-up interview was conducted with the informants, the above two patients had achieved, in actuality, only poor adjustment. Both patients, however, gave evidence by their recent behavior that their potential for further improvement was good. Therefore one can say that at the time of the follow-up interview these two patients had not yet reached that level of adjustment and integration it is assumed they will attain eventually.

Poor Adjustment Level

Only one patient who had been out of the hospital one year attained no better than a poor adjustment in the community. Not only was Mr. H.'s degree of adjustment poor; he also gave no indication that his potential for improvement exceeded the actual improvement (minor as it was) he had made in the year after his hospital discharge. Mr. H.'s sister, the informant, stated that although the patient's stream of speech, affect and mood were normal and not bizarre, he was grossly unkempt and

exhibited total lack of judgment. Mr. H.'s social functioning was minimal, at best. He assumed no responsibility either for himself or for others. Miss H. reported that it was practically impossible to get him involved in the most minor of family activities. He came to the day hospital but he spent the rest of his time looking at television or remaining silently by himself. In spite of Mr. H.'s unsatisfactory adjustment, his sister seemed pleased to have him home and did not indicate that he was too sick to be put out of the hospital. It is obvious that in this case the informant's high tolerance for the patient as well as her low expectations of him had a great deal to do with the fact the patient was able to remain in the community.

CASE EXAMPLES—THREE MONTH FOLLOW-UP

In the group of five patients who had been discharged only three months at the time their informants were interviewed, three had attained "good" adjustment; one had "limited" adjustment; and one had "poor" adjustment.

Good Adjustment Level

Miss K., who, according to the information given by her mother, is to be classified as having attained good adjustment, is in many ways similar to Mr. B., who is described above. Mrs. K. reported that her daughter is neat and clean and takes great pride in her grooming and dress when she goes visiting or to church. She is described as being quiet and still somewhat withdrawn, especially when she is with unfamiliar people. However, she is well-liked by her married sisters and her nieces and nephews and manages to carry on rather lengthy conversations without becoming noticeably anxious.

Miss K. has a room of her own and takes complete responsibility for keeping it clean. She also helps with the housework on the days she does not go to the day hospital. On those days she prepares breakfast for herself and her mother and then tidies up the kitchen. Occasionally she will do the food marketing. Mrs. K. remarked that her daughter is not capable of planning meals or deciding what is lacking in the pantry but that she can be trusted to do the shopping if she is provided with a shopping list. Mrs. K. felt that, generally speaking, her daughter was able to take responsibility for herself. She stated, however, that because her daughter is a diabetic, she had to keep to a rigid diet. Mrs. K. felt that her daughter needed a certain amount of supervision in this area because she was likely to eat improper foods if she were not watched closely.

Miss K.'s social life is fairly limited but this is due to the nature of her family's social life rather than to an inability on her part to make use of the family's normal activities. Mrs. K. is in her late sixties and somewhat infirm. For this reason the social life is limited to Sunday get-togethers with other family members, usually at the home of Mrs. K. Because of this, Miss K. has very little contact with the community; she goes to the day hospital three times a week, but it is doubtful that on any other occasions she leaves the house for any more than a brief period of time.

Mrs. K. was extremely pleased to have the patient home and seemed to feel that her daughter was improving all the time. She said that she did not think her daughter would ever be able to hold a job, but she felt that this was not particularly important as long as the patient was home, and happy. Miss K. is supported financially by two sisters.

Limited Adjustment Level

Mr. J. attained a limited level of adjustment three months after discharge. He was living in a dilapidated apartment with his widowed mother and younger brother, a college student. At the time of the follow-up interview Mr. J.'s actual improvement was very minor. According to his mother he attended the day hospital and was doing satisfactory work in the linen room but he was extremely careless about his appearance and very withdrawn.

Mrs. J. reported that her son assumed no responsibility either for others or for himself and that, in fact, she had to remind him to change his underwear every day. The patient's interaction with family members was also very limited. He would answer direct questions but became anxious and withdrawn when placed in a position where he had to carry on a conversation. Occasionally he would go out for an automobile ride with his brother but for the greater part of the time he would sit in front of the television and would not participate in family activities even when prompted to do so.

In spite of practically no change in the patient's condition during the three months following hospital discharge, Mrs. J. seemed hopeful that, given time and proper therapy, her son would improve. She stated that when her son first started going to the day hospital he would walk to the Massachusetts Mental Health Center, a distance of about 10 miles a day, because he was "too frightened to be on a streetcar with other people." However, after about two months, she noted that he began riding on the streetcar without difficulty. Mrs. J. frankly stated that she viewed this as an improvement and felt that perhaps some day her son would improve in other areas as well.

Poor Adjustment Level

There was one patient who, at the time of the interview, attained only a poor adjustment level. She was a discharge failure in that she was rehospitalized shortly after having been in the community three months. Miss I., who was followed up three months after discharge, failed to attain even the minimal level of social adjustment necessary for extramural existence. Not only did she fail to improve after her hospital discharge; she also deteriorated in both social functioning and psychiatric integration to such an extent that rehospitalization became essential.

Because no family was available, Miss I. went to live in a nursing home where she also worked as a nurse's aide. Her employer reported that at first she was quite satisfactory, but that she soon began to be very dirty and unkempt, that she was hallucinated and deluded and that she showed gross abnormalities in grasp and judgment as evidenced by the fact she would lie down on patients' beds and argue with the older patients. The patient's employer became especially concerned by Miss I.'s behavior after working hours. Promiscuity was suspected and eventually confirmed. Socially, Miss I. was unacceptable to the other employees. They did not like her and some were frankly frightened of her. Because of Miss I.'s inability to adjust to the regime of the nursing home, because of her promiscuous behavior and because of the unavailability of a family or of a more suitable setting, Miss I. was rehospitalized at Metropolitan State Hospital.

DISCUSSION

The information gathered in this follow-up study with the families and/or informants of 13 discharged patients reveals that 11 (over four-fifths of the sample) have made

or are in the process of making sufficient adjustment to their communities and families to have justified the hospital discharge. While only one patient in this group of 11 was gainfully employed and financially independent, the majority of the others had become acceptable and, indeed, useful members in their families and communities. Most of these patients showed promise of further improvement. It is still unknown how much more improvement will take place in the patients who have attained good or limited adjustments. It is doubtful that all of these patients can be completely rehabilitated to the extent that they can assume the roles of normal men and women in our society. Several of these patients will, of course, only reach a certain level of integration and adjustment and then improve no further, but if that level is compatible to the family's and community's tolerance and expectations, one can say that the hospital discharge was justified. It is particularly difficult to predict how many more of these patients will improve because it was noted that patients improve at different rates and that some level off in their improvement after a certain period of time, while others continue to improve indefinitely.

Miss K., who, as was noted above, had a good level of adjustment after only three months is comparable to the patients who had attained good adjustment at the one year follow-up. Whether or not Miss K. will have surpassed people like Mr. B. in terms of total adjustment when she will have been out of the hospital one year remains to be seen. It is suspected, although not proved, that the greatest amount of improvement in these patients occurs within the first few months after discharge and that minor and less dramatic improvements may take place thereafter. It is hypothesized that if a patient is to improve sufficiently to remain in the community he will do so within a relatively short period of time.

This study suggests that the family's and community's tolerance for the ex-mental patient is one of the central factors influencing the success of the discharge. Significantly, it was found that the family's and community's tolerance was extremely high and that their expectations of these patients were unexpectedly low. High tolerance for and low expectations of the patients were evident in cases where the informant was related to the patient and had a strong emotional investment in him. It is not known what caused such high tolerance in the families of these patients. It is hypothesized that the family's tolerance is dependent both on the deep love and interest the families had for their patients and on the guilt feelings the families had regarding their patients' illness.

Only in the case of Miss I. did her bizarre and antisocial behavior exceed the community's tolerance for her. This might be due to the fact that Miss I. lived not with her family but in a setting which was not equipped to take care of such a patient or to tolerate the type of behavior Miss I. presented. In Mr. H.'s case, it was found that even though the patient had attained only poor adjustment and did not show promise of improving in the foreseeable future, his family's tolerance was such that he was able to continue living at home. Objectively both Mr. H. and Miss I. had adjusted poorly but the forms in which these two patients expressed their poor adjustments were quite different. Miss I. behaved in an antisocial manner; she was promiscuous, abusive and unmanageable; Mr. H. was withdrawn, untidy and quietly hostile. It is understandable that the family and community were able to tolerate Mr. H.'s form of poor adjustment and not able

to tolerate Miss I.'s form of poor adjustment.

It is believed that the intensive casework that the families of these patients received both prior to and following the patient's hospital discharge was instrumental in helping the families make suitable plans for their patients. Casework with these families also helped the families mobilize their feelings about mental illness in general, and about their own patients in particular, in a constructive rather than in a destructive way. Of the many factors contributing to a successful discharge of a chronic schizophrenic patient, intensive casework with the families of these patients seemed to emerge as one of the more important and dynamic factors.[10] The criteria for the discharge of a chronic schizophrenic vary from patient to patient. This study has shown that it is not necessary for a patient to achieve an excellent or good level of adjustment in order to remain in the community. It has become evident, however, that the more resources a patient has in terms of family and community supports, the less need there is for the patient to be psychiatrically well and socially adjusted and, conversely, the less support and resources available to the patient, the more necessary it becomes for him to be moderately well in order to readjust to the community.

SUMMARY

This study, a part of a larger one dealing with the drug and social therapy of 60 chronic schizophrenic patients hospitalized for five years or more in a custodial setting and then transferred to an acute treatment center for a period of six months or one year, has described the social adjustment attained by 13 discharged patients. Information on these patients' adjustment to their families and communities was gathered from an interview a social worker conducted either with a member of the patient's family or with some person in the community who had close contact with the patient after his discharge.

It was found that of the 13 patients, nine, or well over half of the group, were living with close family members, and four were living in the community, either at the Half-Way House or by themselves.

The social adjustment of the patient was divided into three separate areas: description of the patient in terms of his personal appearance and psychiatric functioning; social functioning of the patient which included the patient's responsibility for himself and others, his employment and his social life; and interpersonal relationships, which included the degree of the patient's involvement with his environment and his interaction with family members. The degree of the patient's total social adjustment was determined by his combined rating in each of the three separate areas.

The analysis of the 13 discharged patients revealed that 11 had attained, or were in the process of attaining, satisfactory adjustments outside the hospital. Only two patients had not attained satisfactory adjustments; one of these had to be rehospitalized shortly after this study was done.

In examining the factors which contributed to the successful discharge and satisfactory adjustment by the patient, it was noted that the use of drugs, the family's and community's tolerance, resources and support for the patient and the careful discharge planning by the social worker emerged as the most important and vital factors in the discharge process.

[10] A more intensive study of how casework with families relates to a patient's discharge is now in process.

This study suggests that with proper and careful planning and with family and community supports, a significant proportion of severely regressed, chronically ill patients who have been hospitalized continuously for five years or more can successfully return to their families and communities. Moreover, an analysis of these 13 interviews revealed that the families' expectations of the patients were lower and their tolerance for the patients was higher than what the hospital presumed. In fact, the family's high tolerance for and support of the patient in several instances compensated for his limited psychiatric and social adjustment and facilitated his discharge. Consequently, the family's high tolerance for the patient and its low expectations of the patient are to be viewed and utilized as valuable resources to the chronic schizophrenic patient. Proper investigation and utilization of these specific resources might increase the discharge rate of partially well patients to an acceptable, nonhazardous living pattern.

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RALPH M. RUST, PH.D.
JAMES S. DAVIE, PH.D.

The personal problems of college students

This report is one of four dealing with the findings of the research group during the first year's study of the Psychiatric Service Demonstration Project at Southern Connecticut State College (SCSC).[1] This report deals with the kinds and frequency of personal problems present in the student body at SCSC and will attempt to show where students with problems go for help. If the problems were not taken to the Psychiatric Service, the particular reasons students gave for not taking them there were also studied.

Other reports will 1) deal with the nature of the first year's case load, 2) describe some relevant features of the student body at SCSC, and 3) point out some differences between the students who use the clinic and those who do not. These reports will not exhaust the material gathered at SCSC. A number of other approaches to the material are possible but these are outside the scope of this study. The findings to be reported should be regarded as very tentative because of the small sample of the student body studied, the possible variations from year to year and the changing conditions in the college—including the effects of the Psychiatric Service itself. A follow-up to the present study will permit more definite conclusions.

Before describing the present study, some background should be given about the Psychiatric Service Demonstration Project and the nature of the research effort. In the summer of 1958 a series of conferences was initiated by the Division of Community Services of the Connecticut State Department of Mental Health with officials of SCSC and various members of the Division of Student Mental Hygiene of Yale University for the purpose of initiating some kind of psychiatric service for SCSC. As

Dr. Rust and Dr. Davie are associated with the Department of Health at Yale University, New Haven, Conn.

[1] Formerly New Haven, Conn., State Teachers College.

its title indicates, the project was a pilot study intended to demonstrate the usefulness of such a service in this and similar colleges. Since funds were limited, the service and the accompanying research were also limited. The clinical service was provided by one psychiatrist (who spent one afternoon and one evening per week at the college) and by one psychiatric social worker (who spent one afternoon a week at the college). The psychiatrist and the psychiatric social worker held regular conferences with a consulting psychiatrist from the Yale Student Mental Hygiene Clinic.

The Psychiatric Service was designed to and actually did function in much the same manner as the Yale Student Mental Hygiene Clinic. Students were seen on referral from the faculty, the administration, the Health Service or other source or they could come self-referred. During the first year of operation every student who came to the clinic was seen at least once. The one possible exception to this statement was a student who may have had a schedule conflict. No waiting list of any size developed although some students were not seen as long as they would have been had more therapy time been available.

As originally contemplated, the research planned for the Demonstration Project was designed to answer two main questions: 1) What is the composition of the case load at the Clinic? and 2) How do those students who use the Clinic differ from those who do not? In addition it was hoped that the study would provide some general information about the student body at SCSC which would be useful to the staff of the Psychiatric Service and to the administration. The authors undertook the research project because the problems posed were very similar to their research interests at Yale and because they regarded the study as an opportunity to obtain comparative data on the student body of a different type of college.

Two instruments were used to carry out the study. In order to gather information on the case load at the Clinic, a modification of the coding guide in use at the Yale Student Mental Hygiene Clinic was used. The coding guide will be described in some detail in another report. Originally it was anticipated that the same form (with minor modifications) would be used by the Counseling Service at SCSC. It was hoped that a comparison of the kinds of problems handled by both services might clarify the differences in the ways the two services functioned to serve the student body. Later it became apparent that much of the counseling is done on an informal basis and that it would be difficult to determine what students should be counted as Counseling Service users. For this reason a comparative study was not attempted, but the coding guide was used to study the case load of the Psychiatric Service.

Differences between those who used the Psychiatric Service and those who did not were studied by means of the second instrument, a questionnaire which was sent out in the spring of 1959 to one-seventh of SCSC students. The questionnaire, which is described in more detail in another report (5), was a long one requiring approximately an hour to complete. Information was obtained about the student's background and present status, his personal problems and how he deals with them. The questionnaire also included a self-descriptive adjective check list and a revision of the authors' Reported Behavior Inventory (3, 4). Before the questionnaire was sent out it was pretested in an advanced psychology class.

With this brief description of the background and purpose of the Psychiatric Service Demonstration Project, we can proceed to the present report, which is concerned

with the personal problems of SCSC students. The authors were interested in determining what proportion of the student body has personal problems, the extent to which students feel these problems are interfering with the ordinary tasks and pleasures of life and, if they have problems, what they do about them.

Information such as this seemed of considerable importance in planning a psychiatric service. Ideally such a study should be conducted before initiating a psychiatric service but this was not possible here.

METHOD

In the spring of 1959 the questionnaire briefly described above was sent to a random sample of those SCSC students enrolled in the day session. The random sample consisted of every seventh student on the day session class lists at the time the sample was selected. In addition to the random sample all students seen in the Psychiatric Service during its first year of operation were sent the questionnaire. A total of 254 questionnaires were sent out (216 to the random sample and 38 to the students seen in the Psychiatric Service). Each questionnaire was identified by a code number plainly marked in the upper right-hand corner of the covering page. Students were told the purpose of the questionnaire and of the identifying code number in the accompanying letter. Identified questionnaires were used for several reasons: 1) to check on any response bias; 2) to permit the integration of data from other sources, particularly the college and the Psychiatric Service; 3) to allow for later follow-up studies, although such studies are not currently planned; and 4) to identify those students who did not return questionnaires so that follow-up notices could be sent.

The data in the present report came from those 115 subjects (31 men and 84 women) in the random sample who returned the questionnaire. Using only random sample subjects permits extrapolation to the college as a whole—at least within the limitations of the sample.

Using two follow-ups (a letter and a postcard), usable responses were obtained from 56 per cent of the subjects. In order to determine if certain subjects were more likely to respond than others, respondents and nonrespondents were compared on 11 variables. All subjects who were sent questionnaires were used in this comparison, both those in the random sample and those seen in the Psychiatric Service. The 11 variables were: 1) patient status; 2) sex; 3) program of study at college; 4) class at college; 5) intellectual ability; 6) age; 7) marital status; 8) home town; 9) living arrangements at college; 10) type of secondary school attended; and 11) cumulative grade average. This information was obtained from college records.

Of these 11 variables only two showed a significant difference between respondents and nonrespondents. Those students seen in the Psychiatric Service were more likely to respond to the questionnaire than those who were not seen in the Psychiatric Service. Women were more likely to respond than men. Neither of these differences is very big, but both just manage to reach significance ($p<.05$). The fact that women were somewhat more likely to respond to the questionnaire than men must be taken into account in assessing the results to be presented below. The other difference, that patients are more likely to respond than nonpatients, is unimportant here since it happens that only one of the 115 respondents in the random sample was a patient.

What proportion of the student body have problems? Estimates were made of the proportion of the student body who have and are aware of personal problems by asking

several questions. One such question asked, "During the past 12 months have you had a personal problem which worried you?" Sixty-three per cent or five out of eight of our subjects said, "Yes." In another section of the questionnaire the question was asked in a very similar fashion, "Have you ever had a personal problem which worried you?" Seventy-four per cent of the sample responded, "Yes, this year." These estimates are not too far from one another and the manner in which the questions were asked may account for the difference obtained. It would probably be safe to assume that somewhat over two-thirds of the students at SCSC believed that they have had a personal problem which worried them during the 12 month period.

What kinds of problems do students have? The nature of student problems and the frequency with which they occur was determined in a number of ways. In one question students were asked simply to specify the nature of their problems. These problems were then classified into seven different categories: 1) self-concerns and physical complaints; 2) finances and commuting; 3) academic and vocational problems; 4) sexual problems; 5) general interpersonal problems with fellow students and others their own age; 6) interpersonal problems with specific individuals; and 7) interpersonal difficulties with members of their immediate family. Two additional categories were used for problems not easily classified above and for a mixture of problems.

Perhaps the most notable finding about the responses to this particular question was that no single problem was characteristic of a large proportion of the group. The most frequent problem area was category six above (difficulty with specific individuals). Fourteen per cent of the total group reported difficulty in this area. Another four per cent reported general difficulty with their peers (category five). Problems involving finances or commuting were mentioned by 12 per cent of the subjects and difficulties with the family or with specific members of the family were mentioned by nine per cent. The complete breakdown by category is given in Table 1.

TABLE 1

Personal problems reported by SCSC students

Problem	*Per cent reporting problem in this area*
No problems *or* not specified	45
Self-concerns or physical complaints	04
Finances or commuting	12
Academic and vocational	06
Sexual	03
General interpersonal difficulties with peers	04
Interpersonal difficulties with specific peers	14
Family relations	08
"Other"	04
Mixture of two or more	04

In addition to the open-end question discussed above, one asked about the frequency of certain specific problems. Students were asked how often during the current school year they had been bothered by 1) loneliness; 2) nervousness; 3) insomnia; 4) headaches; and 5) indigestion. Of these five problems the one most frequently checked was nervousness. Thirty-five per cent of the students indicated that they had been bothered by nervousness "very often" or "fairly often" during the current school year. About one-quarter (23 per cent) of the students were bothered by headaches during the current school year while 15 per

TABLE 2

During the current school year, how often have you been bothered by:

Item	*Per cent saying "Very often" or "Fairly often"*
Loneliness	15
Nervousness	35
Insomnia	09
Headaches	22
Indigestion	05

cent were very often or fairly often bothered by loneliness, nine per cent by insomnia and only five per cent by indigestion. These data are presented in Table 2.

When asked specifically, students seem to feel that they get along very well or fairly well with males their own age, females their own age, with their mother, their father and with the faculty. See Table 3. Less than five per cent indicate that they get along fairly poorly or very poorly with any of these individuals or groups. If there is any difference in the way they perceive their relationship with these people it is in their relationship with their mother, which is characterized as not quite so satisfactory as their relationship with others, but this

TABLE 3

During the current school year, how well have you "gotten along with":

Category	*Per cent replying "Fairly poorly" or "Very poorly"*
Males your own age	03
Females your own age	01
Your mother	05
Your father	02
The faculty	00

TABLE 4

Compared to other people of your age and sex, how would you describe your physical and mental health?

Item	*Per cent replying "Somewhat worse" or "Much worse"*
Physical health	04
Mental health	05

is a very small difference and is not statistically significant.

Subjects were asked to compare themselves with other people their own age and sex with respect to physical and mental health and similarly to rate themselves on: 1) physical attractiveness; 2) physical strength; 3) athletic ability; 4) dancing ability; 5) intellectual ability; 6) sense of humor; and 7) overall "personality." As might be expected, they tend to judge themselves more favorably than they judge others. The results are presented in Tables 4 and 5.

TABLE 5

Compared to other people of your age and sex, how would you rate yourself on the following traits?

Item	*Per cent replying "Somewhat lower" or "Much lower"*
Physical attractiveness	14
Physical strength	12
Athletic ability	21
Dancing ability	20
Intellectual ability	02
Sense of humor	02
Over-all "personality"	04

Less than five per cent rate their physical health or their mental health as "somewhat worse" than others. No one used the category "much worse" for these variables. On each variable almost two-thirds of the subjects rated themselves as "about the same" but 35 per cent, rated their physical health as "much better" or "somewhat better" while 29 per cent rated their mental health as better than their contemporaries.

In areas somewhat more specific than the rather vague concepts of physical and mental health, subjects do not rate themselves quite so high although the balance in each case but one is toward the high end of the scale. Twenty per cent of the group rate their dancing ability above average and an equal proportion rate it below average. Twenty-one per cent consider their athletic ability either somewhat lower or much lower than average, but 32 per cent consider it above average. Approximately 15 per cent consider their physical strength and physical attractiveness below average but hardly anyone considers himself to be below average in intellectual ability, sense of humor or over-all "personality."

Still another group of questions was designed to measure an individual's satisfaction with his college experience. The items used were adapted from similar questions used by Davie at Yale (1). Some of the items might well be considered indicative of the individual's mental health. The subjects were asked, "In what sort of spirits have you been most of the time at SCSC?" "So far what kind of a time have you had at SCSC?" and "Have you ever felt 'out of place' at SCSC?" Three per cent indicated they had been in fairly poor or very poor spirits; four per cent indicated that they had a fairly poor time or a very poor time; and five per cent said they had felt out of place frequently or most of the time. In terms of taking any action about these feelings, only 13 per cent said they had considered leaving for another college and an equal proportion indicated that if they had it to do over again they probably would not or definitely would not choose to go to SCSC. In terms of their total experience at SCSC to date, only three per cent indicated that they were fairly dissatisfied or very dissatisfied.

It was assumed that students who have problems will differ in the extent to which these problems interfere, or are perceived as interfering, with their normal functioning. In order to determine how students differ in this respect they were asked, "Do you at present have any personal problem which interferes with your 1) studies; 2) athletic participation; 3) extra-curricular participation; 4) recreation; 5) sleep; 6) sex life; or 7) relations with people." The response to this question, in terms of the proportion replying "Yes, seriously interferes" or "Yes, some difficulty" to each of these categories, is shown in Table 6. As might be expected in an academic setting, "studies" is the area most frequently interfered with; over one-third (37 per cent) of the group report interference from personal

TABLE 6

Do you have any personal problem which interferes with:

Item	*Per cent replying, "Yes, seriously interferes" or "Yes, some difficulty"*
Studies	37
Athletic participation	24
Extracurricular participation	33
Recreation	21
Sleep	20
Sex life	15
Relations with people	16

problems in this area. Extracurricular activities are interfered with in 33 per cent of the group and athletic participation is interfered with in 24 per cent of the group. Other areas (which might be considered as less specifically college oriented) are interfered with less. From 15 to 20 per cent of the group report interference in these other areas.

In a previous study, a survey of mental health at Yale, Rust (2) used responses to two questions designed to measure: 1) the extent to which various areas of functioning are interfered with and 2) how frequently the student is bothered by certain specific problems. These questions, the responses to which are presented in detail above, were: "Do you at present have any personal problem which interferes with your 1) studies; 2) athletic participation; 3) extracurricular participation; 4) recreation; 5) sleep; 6) sex life; or 7) relations with people" and "During the current school year how often have you been bothered by 1) loneliness; 2) nervousness; 3) insomnia; 4) headaches; and 5) indigestion." As a rough indication of difficulty, one point was scored for each "Very often" or "Fairly often" response to each specific problem in the latter question and for each "Yes, seriously interferes" or "Yes, some difficulty" response to each area in the former.

A total score of 12 is possible and presumably the higher the score the poorer the mental health of the subject, the more aware he is of his difficulties, or both. Scores on this "Twelve-Problems" scale for SCSC students are shown in Table 7. Viewed in this way all but 22 per cent of the student body have had at least one troublesome problem during the current school year and almost a third (31 per cent) have had four or more problems.

TABLE 7

Twelve-Problem Scale scores for SCSC students

Score	*Number*	*Per cent*
0	25	22
1	23	20
2	17	15
3	13	11
4	9	08
5	13	11
6	8	07
7	2	02
8 or more	3	03

Where do students take their problems? Space was provided on the questionnaire for the subject to indicate whether he had taken his problem to the dean of students, a faculty adviser, some other faculty member, the Psychiatric Service or to some other individual or service. If the subject checked "some other individual or service" he was asked to "specify: friend, clergy, parent, etc." In each case he was asked to indicate whether he had consulted the individual or service and if he had, whether he had been helped: 1) a great deal; 2) quite a bit; 3) some; or 4) none.

Of the 63 per cent who indicated that they had been worried by a personal problem during the 12 months, slightly over half consulted someone about their problem. Only one student consulted the Psychiatric Service; two consulted the dean of students; three, their faculty adviser; seven, some other faculty member; and by far the largest number, 34, consulted someone in the "other" category. Some subjects consulted individuals in more than one category. With such small numbers in all but the "other" category it is difficult to be certain of their relative importance.

The authors' revised Reported Behavior Inventory (5) included six questions on

where students take their problems. These questions elicited a higher positive response than those discussed above. Fifty-four per cent indicated that they have "consulted someone about a personal problem that worried them during the last year." Subjects were asked specifically whether they had consulted their mother, their father, a female friend, a male friend or a faculty member, and whether they had "consulted a psychotherapist (psychiatrist, psychologist, psychiatric social worker, etc.)" Responses to these specific questions probably provide a better idea of where students take their problems than the open-end questions discussed above. Sixty-three per cent of the group indicated they had consulted a female friend during the year; 46 per cent consulted a male friend; 39 per cent consulted their mother; 22 per cent consulted their father; 11 per cent consulted a faculty member and three per cent consulted a psychotherapist. These figures are all considerably higher than the ones obtained in the earlier section of the questionnaire. The questions were worded a little differently and perhaps subjects distinguish between "personal problems" and "personal problems that worry them." Also, since these latter items need only be circled, they are easier to answer than those which require the subject to specify whom he consulted and how much he was helped. However it seems clear that male and female friends are most often consulted, parents next most often consulted (especially the mother), while faculty members and psychotherapists are much less frequently consulted.

Although the authors considered the size of the sample too small to permit analysis by subgroups, the seemingly obvious differential "pull" of these items for men and women made a separate analysis almost necessary. However only the item "consulted a faculty member" showed a significant difference between men and women. Twenty-three per cent of the men and only eight per cent of the women indicated they had consulted a faculty member about a personal problem during the year.

Why is the Psychiatric Service not consulted when the student has a problem? To answer this question, students who had a problem but did not consult the Psychiatric Service were asked if there were any particular reason why they did not. About one-quarter said that there was some particular reason; the remainder either did not have a problem or had no particular reason for not consulting the Service. Six of those 32 students who gave a reason said they did not know the Service existed. A somewhat larger number felt that their particular problem either was not appropriate or not serious enough to warrant such consultation. Often the student's statement of his problem seemed to confirm this estimate. For example, one student stated her problem as, "A friendship with a male became serious on his part and it was difficult to try to keep it friendly without ill feeling." She said she did not consult the Psychiatric Service because, "It wasn't anything demanding such treatment." Another student gave a realistic problem of the illness and death of a relative and stated that she "realized there was nothing [the Psychiatric Service] could do to alleviate the situation."

Other problems, as stated by the student, seemed more appropriate. For example, one said, "I would feel uncomfortable and don't think they could help me." She stated her problem as, "My parents, especially my mother, cannot speak without starting an argument. They belittle everything and everyone I touch." Two or three students expressed some doubt about confidentiality and two or three indicated that

they felt they should be able to handle their own problems. Only one student indicated that there was a problem of scheduling.

DISCUSSION

The present research was designed to evaluate the need for a psychiatric service at SCSC under limitations imposed by 1) the scope of the research permitted by the budget of the Project and 2) the timing of the Project. Within these limitations the research was designed to coincide with the authors' present research interests and past experience. Other investigators might have chosen other topics such as the effects of psychotherapy on those students seen in the Psychiatric Service or the effects of the presence of a Psychiatric Service on the attitudes of college students, administrators and faculty. The authors actually considered the latter study but decided that such effects would probably be too difficult to measure and that a pretest, conducted before the Service was initiated, would be necessary. A study of the effects of psychotherapy seemed entirely too complicated to be considered, although of considerable importance to the field.

A study of the incidence and severity of personal problems and how these problems are handled by the student seemed within the scope of the Project as well as useful for determining the need for a Psychiatric Service in the college. In the ideally designed study, a survey to determine how students handle their problems would have been conducted before initiating the Service. In the present study this was not possible because of time factors.

Once the general topics for study were chosen, several methods for conducting the study were possible. The resulting choice was due to essentially the same factors as those stated above. The authors chose to send a rather long, identified questionnaire containing many personal items to a random sample of the student body. A questionnaire such as this provides a great deal of information with relatively little effort on the part of the investigators. It is also fairly objective, depending less on the interpretation of the investigator than do many other methods. College students are intelligent and co-operative and usually quite interested in such a project, but since the authors were not known either personally or by reputation at SCSC they did not expect to receive a response as high as the 75 per cent usually obtained in previous studies at Yale University. It was gratifying to receive usable questionnaires from over half the sample.

One of the difficulties inherent in a questionnaire study, or in any other study which depends on the co-operation of subjects, is the extent to which the results obtained are truly representative of all the subjects—both those who respond and those who do not. As far as could be determined from the variables tested, respondents and nonrespondents in this study differ in only one important respect: women are somewhat more likely to respond to the questionnaire than are men. It could be assumed, however, that those students who are more suspicious, more reticent, lazier, less prompt or less conforming to authority are less likely to return the questionnaire. If the assumption is correct, these factors undoubtedly affect the results obtained. Nevertheless the authors feel that students should not be forced to return questionnaires. Such a demand is likely to result in distorted responses and less co-operation in future studies and in justifiable difficulties with the administration.

In addition to the difficulties inherent in the questionnaire method discussed above,

other factors should be considered in interpreting the results: 1) a larger sample of the student body would have yielded more reliable results; 2) changes in the nature of the student body from year to year are to be expected; and 3) some changes may occur as a result of the presence of the Psychiatric Service in the college. These factors suggest the necessity for a follow-up to the present study. Such a replication would also permit the study of subsamples of the student body (by combining the data from the two studies). For example, there are undoubtedly differences between men and women in the variables studied and knowledge of these differences, as well as those among other groups of students, would be helpful for future planning.

The results of the present study indicate that a large proportion of the student body has one or more personal problems. These problems often interfere with their studies, with other areas of their college career, or they interfere with normal day to day living. Although the authors do not have a great deal of comparative data from other colleges, that which they have from Yale University undergraduates indicates that the frequency of personal problems at SCSC is approximately the same as for Yale (2). Thirty-one per cent of the SCSC students have a score of four or more on the Twelve-Problems Scale, while 24 per cent of the Yale students had similar scores.

A good many of the problems seem to be realistic, everyday problems which, although troublesome, are solved or improved by consultation with friends or parents. Other problems seem more internal and need the help of professionals. The Psychiatric Service is one important resource for dealing with such problems. At Yale approximately 15 to 20 per cent of each graduating class come to the Mental Hygiene Clinic at some time. Although the proportion at SCSC is certainly much lower at present, as the Service becomes better known one might expect that a comparable proportion will use it.

SUMMARY

In order to assess the nature, frequency and severity of personal problems at Southern Connecticut State College and to determine where students go for help with these problems, the authors sent an 18-page questionnaire to a random sample (one-seventh) of the student body. The results presented in this paper are based on the responses of the 115 subjects (52 per cent) in the random sample who answered the questionnaire.

Approximately two-thirds of the student body have one or more personal problems. On the Twelve-Problems Scale, designed to give a quick estimate of mental health, almost one-third (31 per cent) reported four or more problems.

The most frequent personal problem among those listed on the questionnaire was "nervousness." Over one-third (35 per cent) of the students indicated they have been bothered by nervousness very often or fairly often during the past year.

Relatively few students report any single class of problem (as classified by the authors), but those problems most frequently indicated were "realistic" problems of finances, commuting or difficulties with specific peers.

Students were more likely to report that their personal problem or problems interfered with their studies than with any other of the areas of functioning listed. Thirty-seven per cent of the group reported that personal problems interfered with their studies.

Students are more likely to take their problems to some unofficial source of help (primarily friends, but also parents and

others) rather than to some official source such as the dean, a faculty adviser, some other faculty member or the Psychiatric Service. Of those who gave some reason for not consulting the Psychiatric Service, several did not know of the existence of the Service, while a somewhat larger number felt, rightly or wrongly, that their problem was not appropriate for such consultation.

Although data on the incidence of problems among college students is not generally available, that which is available (on Yale students) indicates that SCSC has a similar proportion of students with problems. It is to be expected that as the Psychiatric Service becomes better known on the campus, more and more students will take advantage of its services.

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JOSEPH H. GOLNER, M.S.

On the unity of religion and psychiatry

This paper is a theoretical attempt to identify common goals of religion and psychiatry in coping with some of the problems of human existence. In this paper religion is defined as any set of doctrines and rites whereby man expresses his relationship to what he calls God. The particular religious point of view represented in this paper refers to certain aspects of the Jewish tradition.

Psychiatry is here used in a limited sense, referring to certain psychotherapeutic influences that are brought to bear upon the understanding and alleviation of mental suffering. The particular psychiatric point of view represented in this paper is based in part on psychoanalytic theory as further developed by Melanie Klein.[1] This paper, moreover, assumes that what will hold true for its particular points of view will have general implications for religion and psychiatry respectively.

Perhaps the key to attaining our objective lies in the interpretation of a Jewish ceremony which occurs annually on the eve of Yom Kippur and introduces the Day of Atonement. This is the ceremony of Kol Nidre of which the Kol Nidre chant itself constitutes only one part. Erroneously referred to as a "prayer," the Kol Nidre is really a proclamation addressed to God. In it the worshipper nullifies certain vows that he has taken. The proclamation reads as follows:

> "All vows, bonds, devotions, promises, obligations, penalties and oaths: wherewith we have vowed, sworn, devoted and bound ourselves: from this Day of Atonement unto the next Day of Atonement, may it come unto us for good: lo, all these, we repent us in them. They shall be absolved, released, annulled, made void and of none effect: They shall not

Mr. Golner is a Research Caseworker in the Department of Psychiatry, Massachusetts General Hospital, Boston. This paper was originally presented at the Community Church of Boston as part of a course on religion and psychiatry conducted in 1959.

[1] See Klein, Melanie, *et al.*, *Developments in Psychoanalysis* (London: The Hogarth Press, 1952).

be binding nor shall they have any power. Our vows shall not be vows: our bonds shall not be bonds: and our oaths shall not be oaths." [2]

The proclamation seems to be one of rebellion and defiance to God. The worshipper wishes to be released from all oaths and promises of loyalty and allegiance that he had previously made to God. It is a kind of declaration of independence from the Yoke of Heaven. Moreover the worshipper submits his proclamation according to certain legal formalities, for the cantor and two elders of the congregation preface the Kol Nidre chant with the following announcement:

"By authority of the Court on high, and by authority of the Court on earth; with the knowledge of the All-Present, and with the knowledge of this congregation, we give leave to pray with them that have transgressed."

It is as if the cantor and the elders of the congregation form a court before which the vows contained in the proclamation will be annulled. For, according to Jewish law, vows that had been made to God could not be annulled except in a court of law.

One might note in passing that the formal preface to Kol Nidre was introduced in the Jewish ritual at a much later date in history for the benefit of the Marranos to whom we shall soon refer in somewhat more detail. The formal preface legalized the Marranos' right to take their places among the worshippers without fear of discrimination. The expression "transgressed" actually refers to apostates or renegades, i.e., the Marranos, who revolted against the Jewish faith. And here we have a hint of what is to come in the Kol Nidre proclamation that follows, for the apostates or renegades among the worshippers are not clearly identified and may include the entire congregation, for whom the cantor and the two elders seek forgiveness. Although the legal procedure postdates the Kol Nidre, it nevertheless seems to provide an atmosphere of sanction to the defiance and rebellion of the old proclamation. Having satisfied all the requirements of Jewish legal proceedings, the cantor then proceeds to chant the Kol Nidre.

While the proclamation is one of rebellion and strong defiance, it is accompanied by a chant whose feeling content is diametrically opposed to the verbal one of the proclamation itself, for the chant seems to express a combination of humiliation, resignation, submission, guilt and suffering. The chant also contains a great longing for reunion, reconciliation, acceptance and forgiveness.

Having submitted the proclamation of Kol Nidre, the worshipper *immediately* petitions God's forgiveness. The cantor and congregation make the following declaration:

"And all the congregation of the children of Israel shall be forgiven and the stranger that sojourneth among them: for in respect of all the people it was done unwittingly."

The cantor then chants the following prayer:

"Pardon, I beseech thee, the iniquity of this people according to the greatness of thy mercy, and according as thou hast forgiven this people from Egypt even until now."

To this plea the congregation responds:

"And the Lord said, 'I have forgiven according to thy word.'"

The Kol Nidre ceremony thus consists of a legal procedure, a chanted proclamation

[2] This translation and all subsequent ones quoted in this paper are taken from Adler, Herbert M., *Synagogue Service for New Year and Atonement* (New York: Hebrew Publishing Company, 1930).

and prayers of penitence. We are confronted by a succession of conflicting feelings and moods—rebellion and defiance on the one hand; remorse, guilt, atonement and hope for reconciliation on the other. The object of all these conflicting feelings is God, the representative of patriarchal authority. Obviously such bold expression of defiance and rebellion is considered to be a sin and is thus a source of great pain and conflict to the worshipper, as expressed in the poignant, tragic melody of Kol Nidre.

In the fifteenth century the Kol Nidre ceremony was given a new meaning by the Jewish people, who were then subject to religious persecution at the hands of the Spanish Church. The Inquisitors of that day forbade Jews to practice their religion under penalty of death and compelled them to take vows that they would disown all ties and allegiance to Judaism. To avoid physical torture and death many Jews took these vows but practiced their religion in secret. The Spanish Church called them "Marranos" which means "swine" in Spanish.

At their first opportunity for religious freedom (when the pressure of the Inquisitors was lifted), the Marranos were eager to practice their religion openly once again and assert their Jewish pride and identity. But an important obstacle remained in their way. The vows that they had taken to give up all allegiance to Judaism were still binding on them. They could not permit themselves to observe their religion with clear conscience.

To gain relief from their painful dilemma the Marranos sought the assistance, strangely enough, of the Kol Nidre ceremony itself. What the Marranos did was give a new meaning to the old proclamation. They replaced the old object with a new object and gave the old vows a new interpretation. What had been a proclamation of defiance and rebellion against God now became a proclamation of defiance against the Spanish Inquisitors. Annulment no longer referred to vows of *allegiance* to God, from which the Worshipper wished to be released. Annulment now referred to vows of *disallegiance* to God from which the *Marranos* wished to be released. And what was formerly considered to be a source of great pain and conflict, i.e., defiance to God, was now a source of pride, for defiance and rebellion against the Spanish Inquisitors was a sign of self-respect. Having annulled the terrible vows that they had been forced to make to the Spanish Inquisitors, the Marranos were finally able to achieve atonement with their God.

The Marranos and the Inquisitors have long disappeared from the scene of history. Yet the Kol Nidre ceremony still holds a powerful appeal for Jews living in modern democratic America, far removed from the autocratic regime of medieval Spain. The Kol Nidre chant itself evokes a sympathetic response in every heart, whether or not it understands the language of Kol Nidre, whether or not it accepts the values of the Marranos. For who has heard the poignant melody of Kol Nidre and not been moved?

It seems, then, that if we can understand the deeper meaning behind the Kol Nidre ceremony and its universal human appeal, we will have come one step closer to identifying the common goals of religion and psychiatry in dealing with some of the problems of human existence.

There are two main ideas expressed in the Kol Nidre ceremony as we have interpreted it, for it lends itself to more than one interpretation. The first idea is the *struggle with inquisitors,* not as the Marranos defined "inquisitors," but in the

original meaning of Kol Nidre, i.e., defiance against God, the representative of patriarchal authority. The second idea expressed in the Kol Nidre ceremony is the theme of *atonement.*

We may now be in a position to locate the focal point on which psychiatry and religion converge, for the two religious ideas, *struggle with inquisitors* and *atonement,* appear to correspond respectively to the two successive stages of emotional development which—in the psychiatric viewpoint of this paper—man must experience individually and collectively in the course of his growing up.

The first stage—*struggle with inquisitors*—is perhaps symbolically represented in the Biblical account of the fall of man in the Garden of Eden. This represents the time of man's life when he experiences the shock of a strange new world. He is then beset by many internal fears which, in his imagination, take on the form of terrible creatures intent on persecuting him.

Man's fears and persecutors disappear when his parents satisfy his various needs, for at this stage in his growth man identifies his parents solely with their physical capacity to fulfill his needs, as if this were the essence of their whole persons. But man cannot always get what he needs or as much as he needs. As a result he feels intense rage and resentment toward the very same parents who give him what he needs. In other words man hates the very ones he loves. He is thus torn between powerful, conflicting feelings of hate and love toward his parents. To solve his great dilemma man splits his parents into "good" parents or "gods" and "bad" parents or "inquisitors" whom he recognizes as his old persecutors.

Man says to himself: "It is the 'good' parents or the 'gods' who give me what I need; it is the 'bad' parents or 'inquisitors' who rob me of what I need." As a result man must destroy the "inquisitors" in order to survive. But if man seeks to destroy them, "they" will retaliate. He must therefore redouble his efforts to destroy the "inquisitors." And so man has created a vicious cycle from which he cannot escape. He becomes engaged in a great witch hunt. He seeks inquisitors everywhere.

The growing pains of man, the limited perception of his parents and his fears of the persecuting inquisitors have all been succinctly expressed in a Jewish legend which states that Adam was expelled from Paradise on the same day on which he had been created.[3] The same Paradise which had been the unlimited source of man's needs suddenly becomes a persecuting angel who brandishes a flaming sword—at the very moment that man consumes the fruit of knowledge and life in an attempt to become omnipotent as God.

To facilitate his search for inquisitors as well as to protect himself from his own destruction, man splits himself into two opposing parts or groups. He identifies himself with one and the inquisitors with the other. Excluding his own group, man may identify the inquisitors with one or a combination of various kinds of groups. "*They* are the inquisitors" who rob him of what he needs and must be destroyed, as if their destruction will give him what he needs. Ironically the inquisitors whom man seeks to destroy include his own group, for man, in turn, becomes an inquisitor for all those whom he calls inquisitors.

The Marranos must have become inquisitors for the Spanish Church at the very moment that the Spanish Church became Inquisitors for the Marranos. The paradox is that the very God of the Span-

[3] *From* Ginzberg L., *The Legends of the Jews* (Philadelphia: The Jewish Publication Society of America, 1909), Vol. 5, p. 107.

ish Church, Jesus, whom the Marranos were forced to worship, was none other than their coreligionist, for Jesus was a Jew. To put it in the language of the Spanish Inquisitors themselves, the God of the Marranos—the Jewish God—was an old and harsh father who had outlived his usefulness and had to relinquish his Divinity to his son, the God of the Spanish Church. It was as if man split God into two parts, just as he split his parents, a "good" or true God on the one hand and a "bad" God on the other, both Gods forever engaged in mortal combat.

But man did more than split his God. He equated the entire meaning and essence of God with the physical, external image of a human figure. Thus the Spanish Church set up Jesus—and, in effect, set itself up—as an idol whom it forced the Marranos to worship. Like Adam before it, the Spanish Church fell into the error of wanting to be as God with omnipotent powers, including the power to destroy those who would challenge the divinity that it had usurped.

The search for inquisitors and the emergence of polytheism, idol worship and murder chiefly characterize man's first stage of emotional development.

The second stage of man's development, *atonement*, gradually replaces the first stage of his development. The transition is not easy and our neat and calm formulation belies what actually happens. The real situation might be more accurately represented by the Biblical account of the Flood. The wickedness of that generation, the unique righteousness of Noah, the subsequent destruction of all life and God's rescue of Noah, his family and animals—all this might well symbolize man's internal emotional upheaval as he struggles to enter his second stage of emotional development. The stage of atonement is characterized by man's ability to bring together his conflicting feelings of love and hate toward his parents. He no longer splits them into good parents or gods and bad parents or inquisitors but he sees them as unitary human figures. As a result man feels guilty over what he has done to his beloved parents, for to the child in man the wish is the same as an act. It is as if man's rage and resentment actually brings about the destruction of his parents. Man feels bad and he wants to resurrect those whom he has destroyed.

Man restores his parents by means of great sacrifices. He creates; he works; he learns. In this way he continually makes reparation for the damage he has caused his beloved parents. By creating, working and learning man continually brings them back to life and keeps them forever with him, not in their physical or human form but in their values, aspirations and ideas. But reparation and restoration is difficult and slow. Atonement, reconciliation and forgiveness are not always possible, for the days of man's parents are limited. The task of reunion, acceptance and atonement must be therefore left in the hands of another power who is not bound by the bonds of humanity but is, in fact, its creator—the master of life and death—whom man calls God. *He* is the one who will accept man no matter how painful his suffering, how slow his growth.

If polytheism was the outcome of man's splitting his parents, then the great discovery of monotheism comes with the unification of man's parents, for the exit of the inquisitors makes way for the arrival of God in the heart of man. And if there are no inquisitors there is no need to split man into parts or identify the inquisitors with various kinds of groups. The father-God of the Marranos and the son-God of the Spanish Church have now become reunited, for in elevating the Son, who is

the embodiment of mercy, to the Divine level of His Father, who is the embodiment of Justice, Christian tradition coincides with Jewish tradition in conceiving of God as the synthesis of Adonoy—mercy—and Elohim—justice. Unity is thus restored to man and God.

Again we realize that our neat and calm formulation belies the great suffering, anguish and hard work that goes on inside the mind of man as he struggles toward maturity. Perhaps some of this can be conveyed by the moving Biblical account of the sacrifice of Isaac. In this account one can experience Abraham's anguish as he sets out to sacrifice his only beloved son to God. But the voice of God intervenes at the appropriate moment, provides another kind of sacrifice, effects the resurrection of Isaac and brings about the reconciliation of father and son.

Sacrifice, atonement and monotheism thus mark the climax and fulfillment of man's second and final stage of emotional development.

It is obvious that individual and collective man does not reach maturity without the help and love of his parents, teachers and prophets. If man receives insufficient guidance he, at worst, may never leave the first stage of his development, or, at best, he may never complete the second stage of his development. Man thus becomes what has been called "estranged" from God. Such estrangement is effectively described in a moving, tender passage which the cantor chants in the Jewish New Year service. This classic prayer represents God as talking to man in much the same way that a father chides his young son, whom the author of the prayer identifies as Ephraim. God is speaking:

> "Thus saith the Lord, I remember for thee the kindness of thy youth, the love of thine espousals: how thou wentest after me in the wilderness, in a land that was not sown. And it is said, Nevertheless I will remember my covenant with thee in the days of thy youth. And I will establish unto thee an everlasting covenant. And it is said, Is Ephraim my dear son? Is he a pleasant child? For as often as I speak against him I do earnestly remember him still: therefore my heart yearneth toward him; I will surely have mercy upon him, saith the Lord."

God is thus represented as longing for man's reconciliation and atonement.

In summary, we have attempted to identify common goals of religion and psychiatry in coping with some of the problems of human existence. The points of view representing religion and psychiatry have been based in part on the Jewish and psychoanalytic traditions. But in reflecting upon the method of attaining our objective, it seems that we have tended to interpret what is religious in the light of what is psychiatric. On the other hand, we have used a religious background to illuminate psychiatric understanding. Thus it has often been difficult to determine where religion began and psychiatry ended. One is therefore tempted to conclude that if our objective was to identify the common goals of religion and psychiatry, our method of approach was to reveal the interdependent nature of their relationship. To put it in the metaphor of the Jewish poet, it is as if religion and psychiatry are inextricably joined as they both lay their hands on the shoulders of man and say to God in unison: "We have returned your son Ephraim to you."

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MARGARET E. HITT, B.S.

The effects of an activity program on chronic psychotic patients

INTRODUCTORY NOTE

The plethora of published writings about psychotherapy for chronic psychotics sets forth clarion calls for action, theories—and often cliches—about what should be done, and well-nigh as many methodologies as there are authors. All too few are articles which tell specifically about what has been done with good effect.

The writer of "The Effects of an Activity Program on Chronic Psychotic Patients" reports a significant project. A woman of skill and infinite patience who admirably empathizes with severe schizophrenics, she spent her time diligently and enthusiastically with her charges. Her story is a warm and stimulating account of their doings and accomplishments. It may be read with interest and benefit by all those who would serve a long-neglected segment of the population of the typical neuro-psychiatric hospital.—Francis H. Deter, Ph.D., Chief, Psychology Service, Veterans Administration Hospital, Murfreesboro, Tenn.

Four years ago the Exercise Therapy Section of the Physical Medicine and Rehabilitation Service at the Veterans Administration Hospital in Murfreesboro, Tenn., selected for study 13 of the youngest and most functionally deteriorated patients from a chronic, disturbed ward. The selected patients were scarcely able to participate in any kind of interpersonal relationships. They manifested indifference toward their own welfare and very little interest in their surroundings. The plan was to have these selected patients undergo an intensive activity program over a sustained period of time in order that they might associate with a permissive, accepting female therapist and eventually effect therapeutic identification.

The supposition was that this group would show positive rehabilitative results if it could have a multiple play-work activity program in a co-operative setting, with ample opportunity for participation

Miss Hitt is a Corrective Therapist at the Veterans Administration Hospital, Murfreesboro, Tenn.

in sympathetically-conditioned real-life situations. The goal was to bring about changes in attitude, greater ability to communicate and an increase in socially acceptable behavior.

DESCRIPTION OF THE GROUP

When two nursing assistants (aides) and the therapist first began activities with these chronically ill patients—all of whom were diagnosed as "schizophrenic reactions" —one could hardly think of them as a group. With the exception of one patient whose talk was loud, repetitious, irrelevant and incessant, all of them were virtually mute and out of contact with reality. Most of them were "soilers." Some often tore their clothing to shreds.

Because the members of the group presented unusual and varied patterns of individual behavior, they were difficult to supervise in outdoor walks. One patient continually ran ahead of the group, making incoherent noises and laughing inappropriately. He was apparently inaccessible and he could not take directions. He avoided the face and eyes of anyone who spoke to him. He was apt to urinate openly and indiscriminately. On the other hand, a second patient lagged to the rear, often lying down and continually needing to be prodded along. Another patient had a mannerism of bending down to kiss the ground at regular intervals. Two others were rigid, one of them statuesque. Almost all of them, preoccupied and listless, wandered aimlessly.

ACTIVITIES AND TECHNIQUES

A variety of activities was used for administering the group process. Included were walks, bus rides, creative rhythm and music sessions, swimming periods, indoor gymnastics, gardening and visits to the library.

A Walk

A walk can be many things. Its effectiveness as therapy is determined by the mood of the group as well as by the interest and physical condition of the individual member. In the beginning these patients hiked at a fast pace. It was as though they were hyperkinetic because of their intense anxiety, as though they were fleeing from an unseen threat. It soon became evident that the rougher the terrain they covered, the farther from the hospital they traveled, the greater was the impact of environmental reality upon them. One incident will serve to illustrate this development. In a secluded byway, the patients had climbed a fence and had alighted in mud on the other side. Each patient, without instruction, stopped at the next dry spot to clean his shoes. None of these men had previously shown such initiative on the ward. The significance of this observation may be far-reaching. It suggests that the "artificiality" of the hospital setting sometimes marshals against reality-testing.

During this activity the patients had their first opportunity for regular and prolonged association with a female other than the ward nurse (identified in their minds with authority). Their first reaction was one of fear and insecurity. They had to test the therapist before they could trust her and before they could feel themselves accepted by her.

Although the therapist had examined the patients' clinical records thoroughly, the walks made possible a clearer and more realistic understanding of each individual in the group. She was empathizing with behaving human beings. It became important that her role in the experiment be made clear. She helped to allay the patients' anxieties by using their surnames only until they began to feel less threat-

ened by her. She called each of them "Mr." She used no pressure to get them to talk. She made impersonal comments. She mentioned the colors of leaves, a flower in the pathway, changes in the natural surroundings. When a patient did volunteer conversation, he was encouraged to continue by reflections and nonverbally communicated approval. Many times the therapist sifted from the patient's irrelevancies what seemed to be his meaning. Then she tried to restate it openly, continuing the interplay of fancy or idea as long as it seemed worthwhile. The talks often revealed delusional ideas (on which the therapist kept notes) peculiar to the particular patient. She eventually turned the conversation to reality, where possible.

Initially the group was so dilapidated that it was possible to note changes or growth in their ability to relate themselves only by nonverbal communication. One man's reaction to the therapist, for example, might be measured only by a slight movement of his body, by a facial expression or in pantomime. Group feeling among the members seemed slight. However, efforts were made to motivate responses by posing choices to the members: for example, which direction to choose for the walk.

Although the therapist and the aides centered their attention on the patients, these attendants soon began to work together harmoniously, sharing and exchanging ideas as their interest in the project mounted. Their spirit of co-operation helped the patients develop a greater feeling of security. On one occasion the therapist worked through an aide to reach a patient who definitely wanted her help but would not tolerate her near him. This patient had passed from a state of depression and muteness to a reaction of extreme agitation in which he writhed and rolled his eyes. However, he very apparently was listening to the therapist's words as she tried to calm him. The aide approached the patient and spoke gently to him: "Did you hear Miss H... tell you to talk and get relief? You've sat too long all bottled up and quiet. Come on and just talk." The therapist was able to come gradually closer as the aide talked. The following day the patient allowed her to come near and he talked to her without the aide's help. In other cases patients showed the ability to relate more efficiently to the female figure. Then the therapist shared her relationship with the aide.

Nearly five months of activity were required before any patient began to express himself verbally. Group feeling and identification, however, were manifested much earlier. Before he was able to speak, one patient began to establish himself as a leader by communicating—with gestures—his suggestions and choices for group activity. The walks continued to be a means for relieving tension.

At this time a female psychiatrist began to hold sessions with half the group. The therapist attended these meetings but did not actively participate. Most of the patients began to verbalize almost spontaneously. Well-nigh immediately they started to talk with the therapist. The result was that the walks became more leisurely and eventually—along the way or resting in the shade of a meadow tree—some patients became comparatively adroit in expressing themselves symbolically. Of course, some talked earlier than did others and two remained mute.

Creative Rhythm and Music Sessions

The first suggestion that came directly from the patients came unexpectedly after they had been attending a music activity. The musician who usually played the or-

gan or piano was absent. The patients were allowed a choice of taking a walk or going to the music room where, with only the aide and therapist present, they could have the room to themselves and could choose and play their own records. One patient expressed surprise and anticipation. He volunteered the information that he had not played a "Victrola" in 20 years and wondered whether he would remember how to operate it. It was obvious that he was excited and felt challenged. Although blocked somewhat and in spite of rigidity of manner, he was able—with help—to operate the record player. Other individuals in the group made selections when the albums were given them.

Although music seemed to make the patients more accessible, it was difficult for them to relax and "feel the rhythm." However, after several months in the music activity they were able to dance as a group. Initially it was necessary for the therapist and aides to work the patients' arms to the rhythm of the music. Often these patients would respond to a quick jig after they had listened to the slow rhythm of several classical records of descriptive music. It was conjectured that the cumulative tensions stemming from inactive listening were finding motor release.

A favorite record chosen by the patients was one called "You Are My Sunshine." It had emotional connotation for them. Perhaps it played upon their repressed longings for a girl of their own and a normal life. This is borne out by thoughts they later expressed in confidence to the therapist. One patient would repeat the words in unison with the vocalist on the record:

> "The other night, dear, as I lay sleeping,
> I dreamed I held you in my arms.
> When I awoke, dear, I was mistaken,
> Then I hung my head and cried." [1]

There were some interesting responses. One patient did solo dances, whirling and spinning wildly and later running to the therapist and whirling her by the hand in a fast waltz rhythm.

Another patient manifested hysterical symptoms. He said he was paralyzed and could not walk. The therapist spent one whole morning leading him and talking to him. She also had the Chief of Exercise Therapy massage him and exercise him. As she took him back to the ward, she suddenly broke into a song with a strong march rhythm. The patient chuckled and began marching in a spontaneous manner. The therapist used this same technique with a rigid schizophrenic patient who was so much out of contact and so apathetic and slow that he had to be pushed along. He marched rapidly when she sang a strongly accented rhythm and led him.

The best plan seems to be to have them listen first to classical records of slow rhythm with a definite tune. Then, when square-dance music—which is almost all pure rhythm—is played, they dance with evident pleasure and make up their own steps. They show more relaxation after music. The activity offers an opportunity for the therapist to find out when a patient is losing some of his tension. The heaviness and stiffness of the hands and arms disappear gradually and he is able to become more spontaneous.

Canteen

Permission for hourly visits to the canteen once each week grew out of a comment sifted from the irrelevant conversation of a patient passing by it one day. Al-

[1] Copyright 1940 Peer International Corporation. Copyright 1957 Peer International Corporation. Used by permission.

though the patients at first showed some apprehension in the canteen, they gradually responded to the freedom of unlocked doors while sipping their drinks and watching the crowds. They had to relearn the use of the Nickelodeon and Coca-Cola machines and how to spend their canteen coupons. Each patient was allowed to move at his own pace.

Finger Painting

The use of finger painting is another tool used successfully in activating the chronic patient. Many times this is a slow process, however, and encouragement by actually moving the patient's hand in the paint until he gets the "feel" of it is sometimes necessary. Music, along with the permissive atmosphere, helps with some. A great deal of time must be devoted to manipulating the patient's hands in the paint to the rhythm of the music. Gradually rigidity seems to recede sufficiently to allow him to fingerpaint alone.

Two primitive methods were involved here—the beat of the music and the touch of the paint as they squeezed and manipulated it. They played in it as children make mud pies. Two of the patients who exhibited marked progress in spontaneity, simultaneously ceased habitual and public masturbation. Although other factors may be involved, it is difficult not to conclude that the finger painting activity served in some respects as a substitute for self-erotic indulgence.

Gymnasium

Activities in the gymnasium were not planned recreational outlets for the patients. Instead, the facilities were used to meet the needs of the patients as they individually showed an inclination to participate or as a therapeutic aid. Some patients who otherwise would have been a management problem were allowed to vent their hostility on the punching bag. Time spent in the gymnasium was extended as the patients became more active and interested in their surroundings.

Swimming

To this group of patients swimming was more than a source of the pleasure usually derived from such activity. The hyperactive patient worked off his tension by constantly diving and swimming from one end of the pool to the other. The catatonic patient relaxed as he stood in the warm water. He would swing his arms back and forth in the water, only to resume his statuesque rigidity on leaving the pool. As the patients became more conscious of their surroundings, they demonstrated an element of unity and comradeship in the pool. There were slow, shy displays of teasing, affection and friendliness and other manifestations of group interaction.

Bus Rides

The nature of the bus rides varied as the needs of the group changed. In the beginning the trips were through the countryside. There was no group feeling. Instead, the patients seemed withdrawn and preoccupied in spite of the therapist's and the aide's efforts to draw them out by pointing out in "sight-seeing fashion," the observable activities of people along the way. As with the walks, it was not until the patients could be drawn into active participation that the bus ride became meaningful and therapeutic.

A trip to the city for a meal was planned, and the patients were permitted to draw funds from their hospital accounts to pay for their food. To test out the current progress of the patients and to stimulate them toward greater responsibility for themselves, we allowed them to keep their own money.

The proprietor of the drive-in cafe (whom the therapist had talked with earlier about the project) gave splendid cooperation in helping the patients feel that they were being given good service when the "chicken-in-a-basket" meal was served on the bus.

Responses to the experience of buying their lunches outside the hospital was conspicuous but varied. Some were unable to eat but others seemed to relish the change in menu and atmosphere. While each was encouraged to pay for his own meal, all were not able to do so. Some showed pride and gained self-confidence from this new challenge, but a few were unable to accept the responsibility. Two had thrown their money from the bus window enroute to the city. Another concealed his money until after his return to the hospital; then he destroyed it. The dynamic significance of losing, hiding or marring money seemed to involve refusal to accept challenges which threaten frustration, rebellion against implicit demands that reality be faced and many other variables.

There were other bus trips to the city, but in the main the rides became shorter and were confined to small towns and rural sections.

These junkets served admirably to arouse interest in other activities by getting these men in contact with new places and a variety of things under circumstances which facilitated their concern and alertness. Once they willingly gathered walnuts with the incentive of making candy later. The anticipation of carrying out this project brought about mixed feelings of desire and fear. Their ambivalence was particularly accentuated by the prospect of making the candy in a private home in the community. Yet when the time came and they were given encouragement, they made their own candy and served their own drinks.

To give the patients further opportunity for being in a family home situation, the therapist invited them to her own home at Christmas. Although they enjoyed the cake and coffee, their pleasure seemed to be mainly derived from the relaxing atmosphere of home surroundings.

Generalizations may be made on patient behavior and the therapist's technique of treatment on the bus rides. When stopping for refreshments at a rural store, the patients could not be induced, at first, to leave their seats, but they showed interest when the therapist described the store and the happenings inside. Eventually those in better condition accompanied the aide or therapist inside. Their resistance came not only from a fear of facing something they had long avoided, but also from the extreme effort necessary for them to make the first step toward community living. To ease their anxiety and to motivate them, the therapist recognized their level of ability to move alone and attempted to help them to experience vicariously that which they could expect to meet.

The patients were not the only ones who had to be educated. Here was an opportunity for better public relations and for practical interpretation of mental illness to a segment of the public. Merchants and other customers at country stores often showed curiosity, fear and lack of understanding. They carelessly offered warm Coca-Colas when cold ones were not in sufficient supply to fill the order; they suggested that the patients would not know the difference. These attitudes seemed to change as they recognized through interpretation and further experience that the patients have feelings, intelligence and rights. Their attitude is now more hospitable, sincere, respectful. Their treatment of the patient now resembles their reactions to their other valued customers.

Psychotherapy

It had been evident for a long time that this group needed professional psychotherapy which the therapist was not fully trained to give. A psychologist met in weekly, joint meetings with the group and gave this type of treatment; he also gave private consultation and guidance to the therapist. This psychologist utilized the established relationship of the therapist with the patients and integrated her knowledge of them into the professional psychotherapeutic approach. More and more the patients freely discussed their feelings about their illnesses and their hospitalization. In many cases the psychologist was able to rephrase their barely intelligible "scattered" language to help them to communicate and gain understanding. The fact that they were being understood encouraged them to try more extensive and coherent verbalizing. It seems that the beginning of understanding or at least the faintest insight into their own problems was an important development as the psychotherapy progressed. The therapist and aide attended all of these meetings.

Group Dynamics

These psychotic patients had no choice about being assigned to the group. At the outset the therapist meant many things to them, and they were quite distrustful. Some showed fear. At times the therapist was threatening because she was a woman. To a few she was a stranger thrust upon them without their knowing why she was there. Yet eventually she was able to help the group feel that she was an accepting and permissive person, and a relationship developed between her and each patient. Some became overtly responsive. Others remained mute but showed positive responses by actions.

Little real group feeling or unity was observable until about eight months after the group was organized.

Shortly afterward there seemed to be more alignments and alliances within the group. It was then that the addition of a new member seemed to become upsetting. Even more disturbing was the unexpected loss of a member of the group when he was transferred to another ward. Sometimes the patients projected their feeling of anxiety by generating hostility toward the therapist. They often lapsed into their former patterns of behavior when they felt insecure. Then they were helped to verbalize their hostility, their frustration and their fear that they might be forsaken. It was only after the therapist had talked with one former patient (and brought back from him word that he was happy where he was) that she could convince the group that his move had been one of promotion and advantage for him.

Although the group members gained security from the therapist's accepting attitude, it was necessary that they also look to her for protection against their own hostility.

Although the therapist gave encouragement and opportunity for oral expression from members of the group, this was possible only in the form of fragmentary comments by a few. Others were only able to show their feelings by their changing expressions and actions. Final agreement was reached that to protect the individual patient as well as the group, it might be necessary for those who might be unable to control their hostile feelings to remain on the ward at times. This "agreement" on the part of the individual members was the result of fragmented and reluctant verbalizations provoked by the therapist. The therapist submitted to each patient, in turn, the dilemma posed by displays of

hostility. She evoked mostly scattered, random language from most and from two new members of the group, only displeasure and negativism. From the clear-cut statements elicited from at least four separate members of the group, however, the distinction between "wanting to hit" and being unable "to keep from hitting" was verbalized. It was agreed that at times he who was too sick to go (who couldn't keep from hitting) should have to remain on the ward. The conclusion was stated by the members of the group themselves.

The relationship between the group and therapist became so close that they were willing to trust her with their innermost thoughts about their delusions and their personal problems. They apparently wanted to share these with the therapist so that she might better understand their feelings and compulsions.

SUMMARY

This paper, which is concerned with four years of daily contact with a given group of chronic, psychotic patients, shows the use that can be made of activities to bring patients from dilapidated and regressed status to more normal speech, feeling and behavior. It demonstrates the gradual development of group cohesiveness and positive relationships and group feelings.

Activities were gradually widened in scope and complexity. To meet the gradual change in the therapeutic needs of the patients, techniques were developed by experimentation, by formal learning and through conferences with other professional personnel.

Timing and sequence of activities were important. This is validated when it is considered that the simple walk helps to bring about rapport. The therapist must have opportunity for individualizing the patients, and the patients need leeway to test out and become more comfortable with the therapist.

Creative rhythm makes the patients more accessible. It helps them to develop and express feeling in a nonverbal manner. Trips to the canteen help bring the patients from the isolation of a subgroup to the community life within the hospital. Finger painting activates the passive patient and provides for catharsis. For some patients, unplanned and self-chosen activity in the gymnasium helps work off hostility, and for others play group activity helps in resocialization. Educational movies foster helpful vicarious experiences and concentration on reality situations.

The progressiveness and increasing complexity of the group activities used in this experiment were based on the patients' changing conditions and their improvement in ability to participate. At the end of four years this group was no longer as passive as it was at the outset, and the majority had improved in their ability to socialize, to act independently and to behave somewhat normally. They were able, to a degree, to converse with others and to participate in activities somewhat spontaneously.

Originally the members of this group included the soiler, the chronic psychotic with various mannerisms and hopeless, fearful, distrustful attitudes and the passive patient, each in his own delusional world. It is believed that substantial progress was made in aiding them to become more friendly, more interested in themselves and their worlds and more willing to strive toward rehabilitation. Perhaps future research, which is direly needed in the area of the treatment of chronic psychotics, will isolate the factors of therapeutic benefit—a task beyond the scope of this study and this report.

JOOST A. M. MEERLOO, M.D.

The psychology of democratic freedom

INTRODUCTION

Thanks to the science of mental hygiene we have become more and more aware that the individual in his normal and abnormal behavior is intrinsically tied up with his environment. Society molds him and he transfers his individual suggestions onto his society. This subtle mutual interdependence points at the fact that political ideologies condition man's mind for the good or for the bad.

The manner in which mental disorders are treated is an indication of man's humane or biased attitude toward his fellow man. Public irresponsibility for mental disorders is a product of immature democracy in which personal rights are egotistically demanded, but responsibilities to fellow men are neglected or denied. That is why I want to investigate what this multicolored word "democracy" signifies to those working in the field of mental hygiene.

What democracy means to man—whether it is a burden or whether it represents the optimum of man's strivings—can only be determined by contrasting democracy with a theoretical counterpoint called, for lack of a better word, totalitarianism.

The totalitarian state, rooted in mutual participation and strict conformity, is continually driving out man's private opinions and convictions. It is actually afraid of individual ideas. In the police state, the most tyrannical form of totalitarianism, independent thinking is considered a dangerous form of action. Man's inner preparation for action, the concept of thought as a *trial* action, is not accepted. Man's innate doubt and the trials and difficulties of thought adaptation are denied. True, inbreeding of destructive thought and its contagious action on others can be very threatening to the community. But not

Dr. Meerloo is a practicing psychoanalyst in New York City. He is also a consultant to the United Nations and teaches political psychology at the New School for Social Research in New York.

trusting the liberty of thought and free expression of opinion artificially represses the destructive part of man's thinking and relegates it to that realm of the mind which may explode more easily into rebellious action. Many dictators forget that to express a destructive thought is often to conquer it. And here lies man's actual paradox! The freedom of subversive thinking often prevents the compulsion of subversive action! It lets steam off! Condemning the antisocial thought, before it has been acted out, may very well provoke the short circuit of explosive action!

I do not think that I am too theoretical in presenting the reconciliation of man's inner antinomies as the core of democratic tolerance. Man starts his life as an ambivalent being. Only democratic tolerance, with its reign of the golden rule, helps man to conquer his inner contrasts.

I realize that every piece of logic has its dangerous implications: inquisitional murder took place in the service of high ideals. If, however, we cannot gamble with the innate good sense of man, a free democracy and peaceful society are impossible. Moral culture begins and ends with the individual. Only the cult of individual freedom, individual possession and individual creativity makes individual man willing to curb instinctual desires and to repress hostility and destructiveness. Man is not only a social being. Somewhere, away from the crowd and the noise of the masses, he has to come to grips with himself and confront his own inner God and nature. He needs reserve and isolation and silence in order to grow. In addition to his mechanical devices and machines, man needs to get back to Nature and camp out-of-doors by himself. Somewhere along the line he has to be the maker of some of his own tools—as an amateur carpenter, shoemaker, healer or teacher. Without being thrown on his own from time to time and knowing loneliness, man is dwarfed, lost among the waves of overpowering and encroaching human influences and victimized by too many social persuasions.

THE DEMOCRATIC ACTION OF PSYCHOLOGY

My most convincing proof of the power of psychological understanding came in the course of protracted mental struggles with a man who held membership in an aggressive totalitarian organization. He came to me for psychological advice during the Nazi occupation of Holland and I knew that I had to be careful to avoid discussing politics with him, for in those days free expression of opinion could be severely punished by the occupiers. My patient would have reported me if I had said anything "suspicious."

However, as my therapy of passive listening gradually liberated him from his personal tensions, the patient became more humane. He developed an increasing respect for the individual personality as such and sometimes grew very critical of the Nazis' callous treatment of human life and human dignity. As time passed, he dissociated himself more and more from his totalitarian political friends. This was indeed courageous, especially at that time, for the turn from collaboration toward nonconformism was usually interpreted as high treason. In his last visits before we agreed that he was cured, we spoke of our mutual faith in the dignity of the individual and our confidence in the decisions of the mature adult as to the path of his own interests.

Can psychology and psychotherapy really exert a democratic influence on the authoritarian and totalitarian spirit? The case I have just cited would seem to indicate that they can. But on the other hand, we know that Goebbels' propaganda machine applied

psychological principles to persuade and hypnotize the German people into abject submission. Hitler, too, laid down his psychological barrage in order to spread panic and passive submission throughout Europe.

In Nazi Germany all psychotherapeutic treatment was controlled by its own Führer, Goering's brother. Certainly the science of suggestion, hypnosis and Pavlovian training can be used to enlist cowardly, submissive followers for a program of despotism. But these misuses of psychological knowledge are perversions of both the principles and the purposes of psychology, for intrinsic in the psychological approach, and above all in psychotherapeutic treatment, is an important element that fosters an attitude diametrically opposite to the totalitarian one.

The true purpose of psychology, especially its mental health branch, is to free man from his internal tensions by helping him to understand what causes them. Psychology seeks to liberate the human spirit from its dependence on immature thinking so that each man can realize his own potentialities. Psychology teaches man to communicate freely and to express himself, unhampered by prejudices and taboos. It seeks to help man to face reality with its many problems and to recognize his own limitations as well as his possibilities for growth. It is dedicated to the development of mature individuals who are capable of living in freedom and of voluntarily restricting their freedom for the larger good of all. It is based on the premise that when man understands himself he can begin to be the master of his own life, rather than merely the puppet either of his own unconscious drives or of a tyrant with a perverted lust for power.

However, nearly every man, in the course of his development, temporarily passes through a stage of greater susceptibility to totalitarianism. This usually occurs during adolescence when the puber becomes aware of his own identity and personality—the authority within himself. To escape the responsibility for being a self he may look for a strong leader outside the home. At an earlier age, in infancy, the more unconscious patterns of compulsion and automatic obedience are laid. With his new sense of selfhood, the youth begins to oppose the adult authorities who previously directed his life.

Becoming conscious of the entity we call ego or self or "I" is a painful mental process. It is not a matter of chance that the feeling of endless longing, of *Weltschmerz,* is traditionally connected with adolescence. The process of becoming an autonomous and self-growing individual (what one may call one's true self) involves separation from the security of the family. To achieve "internal democracy" the adolescent must separate himself from his protective guiding environment. In so doing he is more than merely intoxicated with his sense of growth and emancipation, his need to go beyond the ancient rules. Also he is filled with a sense of fear and loneliness. As he enters this new world in which he must assume mature responsibility for his actions, he may become an easy prey for totalitarian propaganda. A personal grudge against growing up may lead him to forsake the struggle for personal maturity.

This problem is particularly acute in Western society, not only because of the real ideological-political battle we have to face but also because of our methods of raising children. So-called primitive groups impose some measure of social responsibility and participation upon the child early in life and increase it gradually. Our middle-class culture, with its veneration for technology and automation, segregates the child

completely in the world of nursery and schoolroom, and then plunges him precipitantly into adulthood to sink or swim. At this point, many young people shrink from such a test of independence. Many do not want a freedom that carries with it so many burdens and so much loneliness. All too many people don't know how to participate in their community life and do not understand the value of their personal vote. They are willing to hand back their active freedom in return for continued parental protection or to surrender the idea of government for and by the people to political or economic ideologies which in fact substitute for parental images.

Clinically this is also important because many addicts and alcoholics lack the inner freedom and the ego-strength to say "no" to their seducers. They may be the social seducers from outside or the tyranny from inner compulsions.

Youth's surrender of individuality is, alas, no guarantee against fear and loneliness. The real outside world is in no way altered by his inner choice. Therefore the young person who relinquishes his freedom to new parent figures or a new compulsion to conformity develops a curious dual feeling of love and hate toward all authority. Docility and rebellion, submission and hate, live side-by-side within him. Sometimes he bows completely to authority or tyranny; at other times, often unpredictably, everything in him revolts against his chosen leader. This duality is an endless one, for one side of his nature continually seeks to overstep the limits which his other, submissive side has imposed. The man who fails to achieve freedom of action knows only two extremes: unquestioning submission and impulsive rebellion. At this stage the concept of freedom of feeling and thinking is still dormant in him.

Conversely, the individual who is strong enough to embrace mature adulthood enters into a new kind of freedom. True, this freedom is an ambiguous concept since it involves the responsibility of making new decisions and confronting new uncertainties. The frontiers of such freedom of action are anarchy and caprice on the one side and regimentation and suffocation by rules on the other. Yet, I must say, thanks to a compulsive education in the nursery there is too much awe felt for order and regulation. Our technical age coerces nearly everybody into that overawed esteem for bureaucracy, institutions, schemes and technical knobs. Sometimes chaos can be a more productive and creative form of order and the less understanding there is of technical know-how, the less mental submission will be the result.

If only we could find an easy formula for the mature attitude toward life! Even if we call it the free democratic spirit, we can still explain more easily what democracy is not than what it is. We can say that our individualizing democracy is the enemy of blind authority. If we wish a more detailed, psychological explanation, we must contrast it again with totalitarianism.

Democracy is against the total regimentation and equalization of its individuals. Democratic freedom still is a great idea full of the inner ambiguities and nostalgias every human ideal has. Democratic freedom does not ask for homogeneous integration and smooth social adjustment. By comparison, democracy implies a confidence in spontaneity and individual growth. It brings the individual man back into focus as a unique part of the "demos." It is able to postulate progress and the correction of evil. It guards the community against human error without resorting to intimidation. Democracy provides redress for its own errors; totalitarianism considers itself infallible. Whereas totalitarianism controls by whim

and is directed by a manipulated public opinion, democracy undertakes to regulate society by law, to respect human nature and to guard its citizens against the tyranny of individuals and organized pressure groups on the one hand and against a power-crazy majority, on the other.

Democracy always fights a dual battle. On the one hand, it must limit the resurgence of asocial inner impulses in the individual; on the other, it must guard the individual against external forces and ideologies hostile to the democratic way of life.

The inner harmony between social adaptation and self-assertion has to be re-formed in every new environment. Each individual has to fight over and over again the same subtle battle that started during infancy and babyhood. The ego, the self, forms itself through confrontation with reality. Compliance battles with originality, dependence with independence, outer discipline with inner backbone and morale. No culture can escape this inner human battle although there is a difference in emphasis in every family and in every culture and society.

THE BATTLE ON TWO FRONTS

The combination of internal and external struggle, of a mental conflict on two fronts, renders the Western ideal of an individualized democracy highly vulnerable, particularly when its adherents are unaware of this inherent contradiction. Democracy, by its very nature, will always have to fight dictatorship from without and destructiveness and laziness from within. Democratic freedom must battle the individual's inner will to power and also his inner urge to submit to other people. It must battle, too, the contagious drive for power intruding from over the frontiers and so often backed up by armies.

The inherent inner contrast and ambivalence involved in democratic freedom are particularly well-expressed in some neurotic conflicts of those struggling with environmental pressure. These persons are possessed by a wish for differentiation and self-distinguishment, yet at the same time they want affirmation and conformity with the group. People want to belong to a mental hierarchy and at the same time want to oppose it. Often they find a temporary solution of their tensions in the formation of mutual admiration clubs characterized by strict inner cohesion and hostility toward the outside. Mass opinion is experienced as a deflation of personal opinion, yet there is also a wish for flattering acknowledgment from a majority—a multitude of votes. The search for votes and publicity often connotes an idle approval of self-doubt. A belief in collective superiority covers up lack of self-confidence.

The freedom for one to speak and shout always implies the compulsion for the other to listen.

The freedom toward which democracy strives is not the romantic freedom of adolescent dreams—the negative freedom of being without any restraint—but one of mature stature. Democracy insists on the sacrifices necessary to maintain freedom. It tries to combat the fears that attack men when they are faced with apparently unlimited freedom which can, after all, be misused to satisfy mere instinctual drives.

Because it does not exploit man by myth, primitive magic, mass hypnotism or other psychological means of seduction, democracy is less fascinating for the immature individual than dictatorial control. Democracy, when it is not involved in a dramatic struggle for survival, may appear quite drab and uninspiring. It simply demands that men shall think and judge for themselves, that each individual shall exercise his full con-

scious ability in adapting to a changing world and that genuine public opinion shall mold the laws that govern the community.

Essentially democracy means the right to develop yourself and not to be developed by others. Yet this right, like every other, has to be balanced by a duty. The right to develop yourself is impossible without the duty of giving your energy and attention to the development of others. Democracy is rooted not only in the personal *rights* of the common man but even more in the personal *interests* and *responsibilities* of the common man. When he loses this interest in politics and government, he helps to pave the road to power politics. Democracy demands mental activity of a rather high level from the common man. In our new era of mass communication that which goes on in the mind of the general public is just as important as the dictum of the expert. The latter may formulate ideas beyond common apprehension. What matters and what influences the world is what Tom, Dick and Harry are able to grasp from the desert of words. Official formulations and logical conclusions can kill living thoughts so easily and can smother individual thinking in a barrage of words.

The mystery of freedom is that great inner love men have for it! Those who have tasted real freedom will not waver. Such men have to revolt against unfair pressure. While the pressure accumulates they revolt silently, but at some critical moment the revolt bursts into the open. For those who have experienced the necessity of such outbursts, freedom is life itself! People have learned this in the days of persecution and occupation, in the underground, in the camps, under the threat of demagoguery. We even discover such rebellion in totalitarian countries where, despite the terror, the resistance goes on. Listen, especially, to the jokes people tell one another about their regime. That is the hidden way rebellion is expressed.

Freedom and respect for the individual are rooted in the Old Testament of the Occident, which convinced man that he makes his own history and that he is responsible for his history. Such freedom implies that a man throw off his inertia, that he strive for knowledge and accept moral responsibility, that he not cling arbitrarily to tradition. Man's fear of freedom is the fear of assuming responsibility.

Yet freedom can be merely an emotional word appealing to infantile conflicts and frustrations experienced by everyone. It can be used as a catchword to spread the suggestion of unfreedom to those who inwardly don't want to be free. It burdens them with new desires and a feeling of rebellion, while in reality they only want to have the freedom to sleep and retreat. What for one group is the freedom to act and create is for the other the freedom to give in and for a third group the freedom to rebel and face conflicts. Freedom is dependent on our goals in life and our goals depend on our urge to perfect ourselves. For the man from the Orient it may mean the freedom from physical desires, for occidental man the freedom to fulfil his desires. Our Western freedom of leisure is derived from *licere*, literally meaning "being permitted *not* to be occupied, not to be engaged in duties."

Again, there is a negative freedom—not being used as an object of interference—and a positive freedom dependent on self-confidence and self-mastery that will use the active will and self-determination to master oneself.

Freedom can never be completely safeguarded by rules and laws. It is as much dependent on the courage, integrity and responsibility of each of us as it is dependent on these qualities in those who govern

us. Every trait in us and our leaders which points to passive submission to mere power is a betrayal of democratic freedom.

In our American system of democratic government, based on government by consent, three different powerful branches serve to check each other: the executive, the legislative and the judiciary. Yet when there is no will to prevent encroachment and arbitrariness of one by any of the others, this system of mutual checks, too, can degenerate.

Like adolescents who try to hide behind the skirts of parental authority rather than face mature adulthood, the individual members of a democratic state may tend to shrink from the mental activity and alertness it imposes. They long to take flight into a condition of thoughtless security. Often they would prefer the government or some individual personification of the state—an institution—to solve their problems for them. It is such desire and inner apathy that breeds totalitarians and conformists. Like an infant the conformist can sleep quietly and transfer all his worries to "Father State." When the intellectuals —that is to say those who pretend to understand—lose their self-control and courage and are possessed only by fears and emotions, the power of those with prejudice and stupidity gains.

Since within each man lie the seeds of both democracy and totalitarianism, the struggle between the democratic and the totalitarian attitude is fought repeatedly by each individual during his lifetime. His view of himself and of his fellow men will determine his political creed. Opposing and at the same time coexisting with his wish for liberty and maturity are destructiveness, hate, the desire for power, resistance to independence and the wish to retreat into irresponsible childhood. Democracy appeals only to the adult side of man; Fascism and totalitarianism tempt his infantile desires.

Totalitarianism is based on a mechanized narrow view of mankind. It denies the complexity of the individual and the struggle between his conscious and unconscious motivations. It denies doubt, ambivalence and contradiction of feelings. It simplifies man, making him into a servile machine that can be put to work by simple governmental oil. Above all, totalitarianism believes in man as a manipulated insect who has to be directed by infallible governmental instinct.

In every psychotherapeutic treatment there comes the moment when the patient has to decide whether or not he will grow up. The knowledge and insight he has gained have to be translated into action. By this time he knows more about himself; his life has become an open book to him. Although he understands himself better, he finds it difficult to leave the dreamland of childhood, with its fantasies, hero worship and happy endings. But, fortified with a deeper understanding of his inner motivation, he steps over into the world of self-chosen responsibility and limited freedom. Because his image of the world is no longer distorted by immature longings, he is now able to function in it as a mature adult.

TRAINING FOR DEMOCRATIC FREEDOM

Systematic education toward freedom is possible. Freedom grows as the control over destructive inner drives becomes internalized, and those drives no longer depend on control from the outside—by parent or other authorities.

It is the building up of our personality and our conscience—ego and mature superego—that is important. Nor can this development be brought about in an enforced and compulsive way as tyrants and dictators attempt. Their rules can never exist with-

out the supervising iron hand. We must develop the personality through free acceptance or rejection of existing moral values until the inner moral person in people is so strong that they are able to go beyond existing values and stand on their own feet and moral grounds. The choice in favor of freedom lies between self-chosen limitation—the liberation from inner chaos —and the pseudo freedom of unconscious instinctual chaos. To many people, freedom is an emotional concept of letting themselves go, which really means a dictatorship by dark, instinctual drives. But there is also an intellectual concept of freedom, meaning limiting bondage and unfreedom.

Psychological freedom is the freedom of the verifying inner moral person in us. But freedom is far from an unequivocal blessing when we are not ripe for it. There is risk in freedom unless we are able to keep our inner destructiveness under control. One of the most paradoxical struggles we must wage is the struggle against the totalitarian attitude in ourselves.

In order to become free, however, certain outside conditions must be prevented from hampering this moral development of self-control. We have to become increasingly aware of the internal dangers and ills of democracy: laxity, lack of discipline, laziness and unawareness. People have to be aware, for instance, of the tendency of technology to automatize their minds. They have to become aware of the fact that mass media and modern communication are able to bypass people's critical barriers and imprint all kinds of unwanted suggestions on man's brains. They have to know that education can turn us either into weak, uncritical fact factories or strong personalities. A free democracy has to fight against "mediocrity" in order not to be smothered by mere numbers of automatic votes. Democratic freedom requires from the members of society a highly intelligent appraisal and understanding of the democratic system itself. This very fact makes it rather difficult to advertise or "promote" such a political system. Furthermore, inculcating democracy is just as dangerous as inculcating totalitarianism. It is the essence of democracy that it must be self-chosen; it cannot be imposed.

THE PARADOX OF FREEDOM AND LIBERTY

Freedom and social planning present no essential contrasts. In order to let freedom grow we have to plan our controls over the forces that limit freedom. First there has to be guidance and discipline to develop a strong inner nucleus with which to face the unfreedom of the world. Beyond this, however, people must have the passion and the inner freedom to prosecute those who abuse freedom. They must possess the vitality to attack those who commit mental suicide, dragging down other persons in their wake of passive surrender. Suicidal submission is a kind of "subversion" from within; it is passive surrender to a mechanized world without vital personalities; it is the denial of the personality. There exists in our world too much urge for security and certainty. Such a goal finally leads to death and mental surrender, to automation and the mere existence of the computed man, because life in itself presumes an acceptance of uncertainty. People must have the fervor to stand firmly for freedom of the individual and for mutual tolerance and dignity, and they must learn not to tolerate the destruction of these values. They must not tolerate those who make use of the glamor of worthy ideas and values such as freedom and liberty, only to destroy these as soon as they themselves are in power. We must be intolerant of these

abuses as long as the battle of mental life versus death of the free-existing personality goes on.

It cannot be emphasized too strongly that liberty is only possible with a strong set of beliefs and moral standards. Man must adhere to self-restrictive rules—moral rules —in order to keep his freedom. When there is a lack of such internal checks, owing to lack of education or to wrong, stereotyped education, then external pressure or even tyranny become necessary to check unsocial drives. Then freedom becomes the victim of man's inability to live in freedom and self-control.

Mankind should be guaranteed the right *not* to hear and not to conform and the more subtle right to defend himself against psychological encroachment and against intervention in the form of oppressive mass propaganda, totalitarian pressure and mental coercion. No compromise or appeasement is possible in dealing with such attitudes. However, we have to watch carefully lest our own mistakes in attacking personal freedom become grist for the totalitarian's mill. Even our denunciations may have a paradoxical effect. Fear and hysteria further totalitarianism. What we need is careful analysis and understanding of such soul-disturbing phenomena. Democracy is the regime of the dignity and decency of man and his right to think for himself, the right to have his own opinions and even more than that, the right *to assert* his own opinion and to protect himself against mental invasion and coercion.

When the United Nations, as a result of a common effort to preserve man's basic freedoms, can devise rules curtailing mental contagion, menticide and psychological intrusion, it will insure a human right as precious as physical existence, the right of the nonconforming free individual, the right to dissent, the right to be oneself. Tolerance of criticism and heresy is one of the conditions of freedom.

Here we touch a crucial point related to the technique of governing people. There exists, for instance, an intimate relationship between overcentralization of government, bureaucratization, mass participation and totalitarianism.

Mass participation in government, without adequate decentralization that emphasizes the value of variation and individuality and without the possibility of sound selection of leaders, facilitates the creation of the dictatorial leader. The masses then transfer their desire for power to him. The slave participates in a magic way in the glory of the master.

Democratic self-government is determined by restraint and self-limitations, by sportsmanship and fairness, by voluntary observance of the rules of society and by cooperation. These qualities come through disciplined training. In a democratic government, those who have been elected to responsible positions request controls and limitations against themselves, against the inner fraudulence presumptive in every person, knowing that no man is without fault. Democracy is not a fight for independence but a mutually regulated interdependence in the service of surplus-freedom. Democracy means checking man's tendency to gather unlimited power unto himself. It means checking the faults in each of us. It minimizes the consequences of man's psychological limitations.

PSYCHOLOGY AS A GUIDE FOR DEMOCRACY

The modern techniques of brainwashing and menticide—those dictatorial perversions of psychology—can bring almost any man into submission and surrender. Many of the victims of political thought control, brainwashing and menticide were once

strong men whose minds and wills, however, were systematically broken and degraded. But although the totalitarians can use their knowledge of the mind for vicious and unscrupulous purposes, a democratic society can and must use its knowledge to help man to grow, to guard his freedom and to understand himself. The totalitarian ideal of man is the instrumental manipulation of man in the service of the monolithic state; the democratic ideal is the dignity and ultimate value of man as a unique, individual being.

Psychological knowledge and psychological treatment may in themselves generate the democratic attitude, for psychology is essentially the science of the *juste-milieu*, of free choice within the framework of man's personal and social limitations. Compared with the million-year span of human existence and evolution, civilization is still in its infancy. Despite historical reversals, man continues to grow, and psychology—no matter how imperfect now—will become one of man's most powerful tools in his struggle for freedom and maturity.

JULES HENRY, PH.D.

Permissiveness and morality

Permissiveness is the philosophy of child development that stresses the free release of impulse and, according to this view, it is damaging to the child to suffer restraints. Permissiveness, as you know, came upon us in part as a misunderstood expression of psychoanalysis, for from Freud's discovery that the conflict between *distorted* impulses and society caused neurosis there developed the distorted *idea* that neurosis was caused by a conflict between *any* impulse and society. According to this notion the best way to prevent neurosis is to do away with inhibition, i.e., to let the child do what his impulses dictate. It is interesting that Freud's insight became transformed into a sweeping attack on all impulse controls, to the extent that in our age books for mothers urge permissiveness. The reason this occurred, the reasons that a scientific insight was distorted is that everyone, for many reasons, was getting sick and tired of holding himself in. Let us look now at some of the consequences of permissiveness on morality and interpersonal relations.

When a child is permitted at every turn to do what *he* wants to do rather than what will please an adult or make the adult's life comfortable, we get what is called a child-centered society. Now it must be borne in mind that the great civilizations—with all their art, literature and music and dance, with their mathematics and philosophy—have been parent-centered, whether in Europe, America, China or India. Hence there cannot be anything inherently poisonous in a parent-centered society. At any rate it is clear that when the emphasis is always on what the *child* wants rather than on what the adult wants, we lay the basis for detachment from others, and it is detachment from others that prepares the ground for moral confusion.

Dr. Henry is Professor of Anthropology in the Department of Sociology-Anthropology, Washington University, St. Louis, Mo.

I am sure you understand that when I emphasize the importance of what the parent wants, or when I de-emphasize the importance of giving in to the child, I do not mean that children are to be treated like animals, at the beck and call and subject to the whim of the parents. Recognizing the importance of consideration for others and that the parents know better than the child what is good for him does not imply the cat-o'-nine-tails and the straight jacket. There is a strange confusion nowadays in the minds of parents and teachers between authoritarianism and authority, and hand-in-hand with this confusion has gone the notion that the old-fashioned firm and commanding parent was somehow psychopathogenic. The point of view that confuses the strict father of yesteryear, and his reflection in the strict yet kindly teacher, with a harsh humiliating tyrannical bogey, fails to take account of the fact that there is absolutely no indication that children were any crazier in the eighteenth and nineteenth centuries, when parents and teachers were strict, than they are today, when parents and teachers are letting down. Those who equate democracy with permissiveness forget that Washington, Jefferson, Madison, Franklin—all the giants of the Golden Age of American democracy—grew up under firm fathers and mothers and under teachers whose prime pedagogical instrument was the birch switch.

Meanwhile, in emphasizing permissiveness—in focusing primarily on what the *child* wants—we detach him from others and thereby undermine his capacity for gratitude. Now the most important aspect of gratitude is not so much that it exacts repayment for a favor done, but rather that it places upon the child a tie to his parent which protects the child against his *own* impulses. When a child says to himself, "I will not do it because it would hurt my mother and father and they have done so much for me," the child, by desisting from doing what he might wish to do, is often merely protecting himself from danger, from sources *other than* his parents. The problem in permissiveness therefore is that since permissiveness gives all and requires nothing in return, it undermines one of the few devices the parent has for protecting the child against *himself*.

All of this is quite apart from the fact that permissiveness in itself is a relaxation of restraints. It must also be borne in mind that since permissiveness means abandonment of inner controls on his impulses, the child has so little practice in self-restraint that he no longer has any way of being grateful, and hence of protecting himself. It is a complete misunderstanding of gratitude to view it merely as a way of returning to the other person a *quid pro quo*. Thus the equation is simple: permissiveness leads to selfishness. Since selfishness sees no way of giving anything to anybody, the child cannot be grateful. Since he cannot therefore do what the parent wants and since the parent wants primarily to protect the child, the parent has no way of protecting the child from himself except by the use of overwhelming force.

At this point some hard-pressed parents may be silently asking, "How do you reply to the child who says, 'I didn't ask to be born'?" and to this the answer is, "That is true, but you are here now and have been treated well; the life that has been given you without your consent has been made pleasant by your parents to the limits of their ability." Of course gratitude cannot come without practice in its performance. You cannot expect a child who all his life has never been asked to do anything to suddenly become solicitous at the age of six or seven.

Hand-in-hand with the destruction of gratitude goes the elimination of guilt. When permissiveness reigns there can be no punishment, for the child is free as a bird, and where there is no punishment there can be no conception of right or of evil. If a child is supposed to be a free spirit it must be wrong to make him feel that at any time he has fallen from grace, so to speak, that he has violated an ideal and has wounded his parent. Hence he cannot experience guilt and so loses the second most important internal control our culture affords. Gratitude and guilt are, along with love and jealousy, the great social emotions; they are the pivot of our civilization and the keystone of morality. Permissiveness threatens them all.

Let us consider, for a moment, the problem of love. The essence of love is still contained in the somewhat sugary expression, "We are two hearts that beat as one." Now a person who has not learned to control his impulses cannot hear the other person's heart beat for he can hear only his own. Thus there is a lack of binding between him and the person he presumably loves, and he cannot heed the loved one's wishes nor become involved in his welfare. He is not loving, however ardent he may appear. From consideration of adult love we may pass to a consideration of the love of a parent for a child. Inseparable from the idea of love is the idea of protection, for the one who loves wants to protect the thing he loves. But a permissive parent is not protecting his child, for he lets him do what he pleases, lets him get into danger.

I would like now to turn to a consideration of the child-centered society, for this problem is tied tightly to the philosophy of permissiveness. In a child-centered society the parent must think primarily of what is good for the child and must submerge his own feelings and needs. Let us for a moment transfer our thinking from the home to a hospital. In a hospital that is staff-centered, that is to say where arrangements are largely for the benefit of the staff —to make their work light and easy and simple—the patients suffer, for they are treated like things not like human beings. But the staff is happy; the doctors, the nurses and other help have it easy: they don't have to worry about the whims of individual patients. In other words they know exactly what they are doing all the time. But in a patient-centered hospital the staff must always worry about whether they are doing the right thing, for their movements are influenced by the unpredictable, whimsical patients. Thus the atmosphere in staff-centered and patient-centered hospitals may be very different. Obviously the ideal situation is where a compromise has been worked out between the two systems.

Now we confront a similar situation in dealing with children. In parent-centered cultures like traditional India and China and, for that matter, in most of the rest of the world outside the stream of industrialized society, the parents' will is law, and it never occurs to a parent to question his own judgment about what is best for his child. Nevertheless the children grow up to be sound citizens and in creative *cultures* some of the *children* become creative. In a child-centered culture like our own, on the other hand, parents are uncertain about their own judgment because they should not organize their behavior in terms of what *they* feel is right but what is right for the child and they are worried that the two might not coincide. Since the parent in a child-centered culture is uncertain in his judgments, the easiest way out is to let the child do what he pleases. This is the primrose path of permissiveness, often mistaken for democracy. If there is anything that is the hallmark of a parent-

centered culture it is adult disorientation; in these circumstances permissiveness is mistaken for love and disorientation is both its reflection and consequence.

I have said that our civilization pivots on the great social emotions of love, gratitude, guilt and jealousy, and it is a striking feature of our current literature that the last three—gratitude, guilt and jealousy—have gone out of style as literary themes although love remains. To me one of the frightening things about love nowadays is the fact that jealousy is declining. Necessarily, however, it must, for as deep involvements in other persons become more and more difficult, as people become more and more self-indulgent, jealousy naturally declines as an emotion of our civilization. But when jealousy declines people lose their hold upon one another.

Up to this point I have stressed that permissiveness leads to lack of concern for others and hence to the decline of gratitude, guilt and the other emotions of personal involvement, the emotions that entangle us wholesomely in the welfare of others. I am sure that it can now be understood why a philosophy of permissiveness must lead to a decline in moral values, for since the root of morality is concern for others and since permissiveness tears up that root, there can be no clear concept of right and wrong outside of that given us by the police.

In this situation the current emphasis on sex education for the young plays a paradoxical role, for the "new" education emphasizes to the children the fact that sex is fun, as if they didn't know it. But the issue here is not that they are being told that sex can be pleasurable, but that the adults are emphasizing to the children again the wonders of permissiveness, of cutting loose and having a good time. None of this is inherently wrong. The danger lies in the fact that beating the drum for sexuality merely drives home a lesson already learned perhaps too well: that adults don't want children to be restrained. What is also taking place is that the adults are ignoring the substance for the shadow, for the problem of youth is not a sexual one in the sense of inhibition and frustration—otherwise all our grandparents and great-grandparents back to Abraham and Sarah would have been lunatics—but a problem in simple human decency, and the problem of decency is the problem of morality.

Let us now take a brief look at contemporary schools. It will be recalled that John Dewey believed that under proper conditions of teacher enlightenment, small classes and adequate materials, children could be permitted much more freedom than they had received in the nineteenth century, and that in this way much of their potential for learning and creativity could be released spontaneously, carrying humanity forward to new and unimagined levels of self-realization. The spontaneity of which Dewey dreamed was therefore to be released in the proper measure and under the proper conditions of wise guidance, understanding, etc. In contemporary circumstances, however, these conceptions of Dewey have been deformed by the philosophy of permissiveness to such an extent that some nursery schools have become jungles in which the freely released impulses of the young belabor one another and engulf the teacher. In those nursery schools where the philosophy of permissiveness prevails, the teacher becomes reduced to a mere buffer whose job it is to prevent the children from tearing toys from each other's hands and hair from each other's heads.

It is necessary to explain why nursery schools have a tendency to become arenas

in which babes are martyrs *and* tigers, both at the same time. When a child enters nursery school he comes into an environment where he does not know the children and where property (i.e., the toys, etc.) is unclaimed. That is to say, the children are strangers to him and *continue* to be so in good part, for he sees them only for a short time each day, and there is a constant shift of population because some children are always sick, some move away and new ones are coming in. Thus to a certain extent the nursery school child in a busy urban school is constantly encountering strange children. This is scary enough for him. But in addition to this the toys and other property are unclaimed; unlike the conditions in his own house, there is no mine and thine in the usual nursery school and it is first come first served. This throws the children into competition, and any nursery school teacher knows that she spends perhaps a third of her time defining the rights of embattled children over the toys. Furthermore, the spacial arrangements in a nursery school are different from the arrangements at home; everything is in a different place, and we know how upsetting it is to children not to have things exactly where they want them. Finally there is the problem of the personal community, the little group of children a child can play with. In a nursery school a child has to make friends anew each day, and even if he does not have to do this the instability and novelty of the situation can throw these babies into a real Darwinian jungle of competition with one another for pals for the day.

The nursery school has all the conditions for the creation of a battlefield where babies may pit their blind impulses against one another. In this situation the permissive atmosphere of some nursery schools merely facilitates bloodshed or at least "tearshed." What is needed is something between the jungle and the prison, a benignly regulated school—interestingly and creatively programmed—in which not only the children but the teacher can find satisfaction, where the teacher will derive her major rewards not from adroitly disentangling Mary's fingers from Johnny's hair, but from knowing that her children have learned something more than how to get along in a jungle.

But it is not only the nursery school that has been hit by the double blight of misunderstood Freud and distorted Dewey, for we encounter the same problem in elementary schools. In elementary school classrooms run on permissive lines the students and teachers often have a wonderful time under conditions of near chaos. Although it has been believed that permissiveness is the ancestor of creativity, one can sometimes note that in such classrooms both teachers and students often become exhausted by the turmoil and little is created except chaos itself. In permissive classrooms children cannot hear; they lose track of the lesson through the noise; they may not do the assigned work and the teacher may end up in a state of exhaustion. Thus in large classes where the teacher may have had no training in dealing with the released impulses of such a big group, creativity and spontaneous learning—the very factors that Dewey's philosophy aspired to develop—may be destroyed. It goes without saying that in such classrooms there is no room for moral teaching, for disorder is antagonistic to morality by definition. Of course it does *not* follow that there *is* moral teaching in *controlled* classrooms; our researches over the past six years have found precious little in either.

One final word on the origins of permissiveness in the American family. Women have a "minority group" psychology.

Barred from the exciting jobs and from the trumpeted prestige statuses of our culture, women seek their primary gratification in their children. Here arises the paradox: namely, that a mother should discipline her children while loving them and many mothers, because of their minority group psychology, or for other reasons, find this intolerable, for to them, to discipline a child seems to them to threaten the mother with loss of the child's love. The resolution of the dilemma is permissiveness, to let the child do what he pleases. Furthermore many mothers feel unconsciously that since their *own* lives of self-restraint got them nowhere, they are not going to subject their own children to such useless frustrations.

Meanwhile, what of the father? Nowadays as fathers grow closer to their children, as they become more like mothers and descend from their formerly aloof and austere positions of imperious authority, they more openly seek the warmth of their children's affections. But this being the case, how can they continue to impose paternal authority—which means imposition of impulse controls on the child—if mother is permissive? The result of this conflict is that father becomes permissive just like mother, and the consequence is that when children are asked to write compositions telling what they like most and what they like least about their mothers and fathers they often say that the reason they like one or the other parent is that he or she "lets me do" things often. Thus there is no doubt that children often tend to turn more to the parent who "lets me" and away from the parent who "won't let me." All of this is aided and abetted by the ascendancy of the philosophy of permissiveness, and thus an idea, born in the industrial system and shaped somewhat through a distorted view of Freud and Dewey, enters the home by the back door to disrupt the relations between parents; and thus it is that a family conflict over who will be the most permissive ultimately undermines the child's capacity to make a moral judgment.

Book Reviews

UNDERSTANDING MENTALLY RETARDED CHILDREN

By Harriet E. Blodgett and Grace J. Warfield

New York, Appleton-Century-Crofts, Inc., 1959, 156 pp.

The writers of this book have a unique opportunity for observing and understanding retarded children. Dr. Blodgett is program director and psychologist and Mrs. Warfield, a teacher in The Sheltering Arms, a day school and research program for retarded children in Minneapolis, Minn.

A basic philosophy of The Sheltering Arms is given on page 92: "The truly qualified teacher expects to find the child interesting; she knows that some part of working with him will be rewarding and pleasurable, whatever the nature of his problems." Without doubt, this attitude has been one reason the school has been able to secure the unusual co-operation of parents in gathering information basic to research needed for greater understanding of retarded children.

The authors have given an abbreviated coverage to the whole field of mental retardation in the 156 pages of the book; they have also provided a full and detailed report on the activities of the school. Basic concepts as well as psychological interpretation and growth patterns are covered. National trends and a succinct account of Minnesota's state program for the retarded are also included. It is indeed a short, clear and valid word picture of the retarded child and an exposition of the definition and meaning of retardation.

This over-all coverage gives one the feeling that certain chapters are primarily of value to one group of readers, and other chapters to other groups. For instance, Chapter III, Mental Development and the Measurement of Intelligence, and Chapter IV, Mental Retardation (a general view) should certainly be only reviews for teachers or other professional persons in the field.

This very fact adds a group (not mentioned by the authors) to those who should find this book useful—students. The bird's-eye view given here should be of value to students who need to understand and expect to work with the retarded, whether in the field of medicine, education, psychology, social work or nursing. However, it is written especially for parents and teachers. The details on teaching methods, understanding of children and their parents and the parents' reactions make it a real guide for both of these groups.

Basically, however, this would seem to be a book that can be looked upon as a first report on this challenging project. It is based both on the information gleaned and knowledge acquired through observation of retarded children under controlled conditions and the careful documenting of the methods used and responses obtained in the school program.

One hopes and feels sure that other reports can be expected from time to time. Perhaps some reports will be more definitely geared for use by a particular group, whether it be teachers, parents, students or the "general public." Those who read this book or who have observed the program will eagerly look forward to later publications, knowing they will have implications that may prove to be a basis for changes in concepts or in methods of training retarded children.—MILDRED THOMSON, Minnesota

Association for Retarded Children, Minneapolis, Minn.

COOPERATIVE PROGRAMS OF TRAINING AND RESEARCH IN MENTAL RETARDATION: THE AMERICAN ASSOCIATION ON MENTAL DEFICIENCY PROJECT ON TECHNICAL PLANNING IN MENTAL RETARDATION

By Darrell A. Hindman

Yellow Springs, Ohio, The Antioch Press, 1959, 160 pp.

In reviewing Dr. Hindman's study one is impressed with the fact that he has pointed up the need for more information regarding co-operative relationships between universities or colleges and institutions for the retarded, and he indeed has shown the need for more co-operation. It is realized that to gather, interpret and present such information is difficult, but we wonder if a less narrative type of presentation might have been more effective.

The fact that there seems to have been no really objective plan for selecting the institutions studied can be understood as there were no precedents to follow. On the other hand the material on some of the institutions sounds like brochures and rosters of professional staff of the institutions rather than a listing and analysis of co-operative programs. With due appreciation to Dr. Hindman for the stupendous task of gathering and presenting the material, this reviewer would like to raise the question of a different form of presentation in later reports, as certainly this is a project of longer duration and this report only an initial one.

It would seem that there is a minimum amount of general information needed on each institution, such as number and type of patients cared for and the distance of the institution from the university. Knowing these and perhaps other facts would give a basis of evaluation for other superintendents in determining whether their own conditions are comparable. The next step might be to analyze the types of co-operation under such headings as Internships for Students, Research by University or College Professors, University Courses Conducted by Institution Staff. An outline could then be prepared and followed for all projects. This might include discipline involved, cost and how financed, purpose, how conducted, etc. Would it then be necessary to list all persons involved or only the person or persons who could give more information to an interested superintendent or professor?

It would seem such an arrangement of material would make it more accessible as a source of help to others who wish to inaugurate some co-operative plan. In spite of the above suggestions, this reviewer believes that persons interested in a closer relationship between institutions and universities or colleges will do well to read and study this report and will find much that is not only helpful and interesting, but challenging.—MILDRED THOMSON, Minnesota Association for Retarded Children, Minneapolis, Minn.

NEW WAYS IN SEX EDUCATION

By Dorothy Walter Baruch

New York, McGraw-Hill Book Company, Inc., 1959, 256 pp.

The something "new" in *New Ways in Sex Education* refers chiefly, I think, to the

emphasis the author places on the psychological rather than the physical nature of sex. Although, strictly speaking, this is not a new emphasis, it needs to be presented—as it is here in this book—clearly and effectively for the guidance of those adults who seek to guide children toward an appreciation and understanding of their sexuality.

Dr. Baruch presents this concept in a variety of ways. Many pages are devoted to the conversations between children, children and parents, children and teachers. These revealing and candid quotations will be helpful to adults.

Other ideas are presented effectively by having statements set up in special form. For example:

In sex education
LOVE is needed
to nourish LOVE.
and . . .
In sound sex education
Feelings COME FIRST.
and . . .
Children ASK about sex
in MORE WAYS
than with
WORDS.

We know that no single book dealing with sex education of children will meet the needs of all parents and teachers. This book, it seems to me, will be particularly helpful and acceptable to parents of young children in homes where conditions lend themselves to the kind of close family relationships that make good communication possible.

For the homes where these relationships do not exist, where communication is blocked or stifled, what kind of book must we write?—ELIZABETH FORCE, American Social Hygiene Association, New York, N. Y.

SYMPOSIUM ON PREVENTIVE AND SOCIAL PSYCHIATRY

April 15–17, 1957. Sponsored jointly by the Walter Reed Army Institute of Research, Walter Reed Army Medical Center and the National Research Council

Washington, D. C., Walter Reed Army Institute of Research, 1958, 529 pp.

This book contains a collection of 31 papers delivered at a three-day meeting and, as is usual on such occasions, the papers varied widely in quality and in relevance to the central theme.

Despite its uneven character, the book is worth reading because it does include some excellent articles. One good section deals with "The Significance of Leadership for the Mental Health of Groups." In this section Brigadier General S. L. A. Marshall, E. Paul Tarrance, James S. Tyhurst, Fred E. Fiedler, William A. Caudill, Robert J. Lifton and Francis H. Palmer present short papers on their studies of leadership behavior, chiefly under battle or other stress conditions. A significant emerging theme is that leadership is not an unchanging phenomenon but is best understood in terms of the interactive process between leaders and followers, and this process varies according to the current life situation of the group. Sometimes the needs of the followers demand a "therapeutic," warm, accepting set of behaviors from a leader, and sometimes the pressing need is for the leader to initiate action with courage and foresight as a decision maker and task leader who raises morale by assuring the hopes of success in those who follow him.

Another section of the book deals with "Social Psychiatry in the Community," and contains three excellent papers: one by

G. R. Hargreaves, who reviews current developments in Great Britain; one by Willem L. Meijering, who does the same for the Netherlands, and one by Robert W. Hyde, who reviews trends in social psychiatry in the United States. The authors provide a panoramic view of the new developments in the community oriented organization of preventive, therapeutic and rehabilitative services.

The section also includes a most interesting paper by Lieutenant Colonel Bruce L. Bushard, who discusses the new philosophy underlying the U. S. Army's Mental Hygiene Consultation Service. This paper, which has clear implications for civilian community psychiatry, points up the limited value of much of our routine practice of time-consuming individual diagnosis and psychotherapy, which is based on identifying and correcting weaknesses in our patients. In place of this approach, it describes a service which tries to stimulate a patient's "commitment" to grapple with his life problems, which exploits his ego strengths and stimulates the supports of his environment, and which counteracts the "concurrence" of significant others with his impulses to abdicate into illness.

Among other interesting papers, the book includes a brilliant article by Fritz Redl who analyzes the meaning of our concepts of the "Therapeutic Milieu." A clear and incisive analysis of the epidemiology of mental illness in troops during warfare is provided by Colonel Albert J. Glass. An excellent theoretical paper by Chris Argyris analyzes the lack of congruence between individual personality needs and the demands of the organizational system of a factory, which are significant in the causation of mental ill-health in industry. A paper by James S. Tyhurst describes some of his studies on the natural history of the psychological manifestations of people in "transitional states," caused by natural disasters, by migration, and by job retirement, all of which have significant implications both for models of etiology of mental disorder and for planning programs of preventive psychiatry.—GERALD CAPLAN, M.D., Harvard University, Boston, Mass.

THE DISTURBED CHILD

By Pearl H. Berkowitz and Esther H. Rothman

New York, New York University Press, 1960, 204 pp.

Since children spend such a large portion of time attending school, these authors believe that "teachers are in a unique position to observe their behavior." Recognizing that the teacher is not primarily a diagnostician, the authors nevertheless maintain that in the ordinary classroom "the teacher is frequently able to help the child who is emotionally disturbed by providing him with a therapeutic situation within the confines of the schoolroom."

Chapter headings indicate the scope of the book: the need for recognizing the disturbed child; the schizophrenic child; detecting symptoms of organic malfunctioning in children; the neuroses; behavior maladjustments; sexual deviates in children; the psychopathic personality; the teacher and the disturbed child; personality projection through verbal expression; the creative arts; the academic curriculum; transcript of a classroom session.

The book is rich in actual classroom cases and situations.—W. CARSON RYAN, Ph.D., University of North Carolina, Chapel Hill, N. C.

AMERICAN HANDBOOK OF PSYCHIATRY

Volumes I and II

Edited by Silvano Arieti

New York, Basic Books, Inc., 1959, 2,097 pp.

If the reviewer stated in the beginning that this is the most monumental work that has appeared upon the psychiatric scene, he would not be far wrong because such was the obvious intent of its editor and his editorial board.

Never before has it been possible to prevail upon over 100 professional persons—each recognized in his own field—to collaborate in the publication of a comprehensive encyclopedia of this nature. It is more than a handbook, more than a source book. It is a serious and thoughtful compilation of what is known about psychiatry today. To bring such a mass of material to the point of readiness for press is no mean task in itself when one recognizes the divergent although valid opinions held by psychiatrists. This is recognized by the editor when he states; "Two or three of our contributors disagreed with the editorial policies but participated nevertheless." He further grants the participants complete freedom to express their views when he states; 'The views expressed in the various chapters are the responsibility of the respective authors and do not necessarily represent those of the editor, the editorial board or the publisher."

What better background could we have for the presentation of facts that are known and are a part of the history of psychiatry, of theories about which there are at times conflicting opinions or of assumptions which cannot be proved or for that matter disproved? Never before has the reader been presented with such an opportunity for serious thought and reflection.

Volume I is divided into seven parts. Part One deals with "Topics of General Interest" and contains three chapters which seem, to this interviewer, to be of extraordinary interest. They are: "American Psychiatry from the Beginning to World War II," "The Psychiatric Interview" and "The Psychiatric Examination." Part Five is concerned with "Psychosomatic Medicine." One of the reviewer's friends, a prominent internist, states: "this is phenomenal; it reads like a novel."

In Part Six, the article on "Psychiatric Problems of Adolescents" is of special merit. In fact all material dealing with children is excellent, the article on mental deficiency being outstanding.

Volume II will challenge the interest of the clinician for it deals with clinical entities and their therapy. Part Eight, "Organic Conditions," is exceptionally well-done and very appropriate in view of the increase in our aging population. Part Nine, "The Therapies," contains valuable historical data and certain parts leave the reviewer with the feeling of nostalgia, probably because of his own bias which he feels free to entertain because such privilege was accorded the individual authors by the editor and the editorial board.

Part Ten, "Psychoanalytic Therapies," is of both current and historical interest. Here one finds much less that is controversial than one would ordinarily assume, because underlying these therapeutic approaches is a basic concept of the patient, his individual worth and an approach to his problem that is more or less common to all who would help him. Part Eleven, "The Physical Therapies," is one of the best sections of Volume II. It is clear and explicit, stating what is known about physical therapies as well as what is not known. It deserves to be studied carefully and thoughtfully in view of the attitude of

desperation which one frequently finds in his colleagues who are continually baffled by the patients' refusal to respond to their best efforts.

Part Fifteen, "Legal Administrative Didactical and Preventive Psychiatry," serves to make the work complete although it may not have the wide appeal which other chapters possess. It is worth special emphasis for this reason alone as it illustrates the intent of the editorial board to present for the reader all aspects of American psychiatry.

In summary, two significant facts merit special attention. In the first place, the articles themselves are stripped of all unnecessary verbiage. The authors say what they have to say on the subject and this without undue use of complicated vocabulary and complex sentences. I would not want to give the impression that these are summaries because this definitely is not true. At no time does an author shirk the responsibility to "come to grips" with his presentation, but points once made are not belabored and this will be appreciated by all readers.

Special mention should be made of the carefully prepared bibliography which each author includes at the end of his presentation. One can scarcely imagine anything in psychiatric literature which has escaped attention. The chapter on schizophrenia, for example, contains 176 references. In "General Concepts of Psychosomatic Medicine" there are 76 references. All of this is further indication of the thoroughness with which the authors have prepared their material. A name index and a subject index complete the work.

A reviewer usually indicates the segment of the reading population for whom any book will have special appeal. This reviewer will reverse the process by stating that no one in the field can afford to deprive himself of the pleasure of ownership. He can only agree with his internist friend, "It reads like a novel." You can pick it up, you can lay it down, but you will always return for hours of pleasurable reading.—MILTON E. KIRKPATRICK, M.D., The Henry Pollack Memorial Clinic, Long Branch, N. J.

PREDICTING DELINQUENCY AND CRIME

By Sheldon and Eleanor Glueck

Cambridge, Mass., Harvard University Press, 1959, 283 pp.

The authors emphasize that in this book they are making a pioneer attempt to present an entire system of predictive devices for delinquents and criminals covering the span of years from the individual's first court appearance until approximately the age of forty. The prediction tables are based on the concept that certain characteristics in the make-up and background of different types of juvenile and adult offenders bear significant relationship to variations in their behavior during and following peno-correctional treatment. Research projects in this area were begun in 1925, and the first prediction tables were published in 1942.

A comparison is made between this (Glueck) method and the Burgess method. The latter method gives equal weight to numerous factors found to be differentially related to success or failure on parole while the Glueck method employs only those factors (usually five) that have been demonstrated, through follow-up studies, to bear a high relationship to subsequent behavior.

For example, the five factors involved in prediction of behavior of the male delinquent on parole are: birthplace of father,

birthplace of mother, discipline by the father, discipline by the mother and school misconduct.

In attempting to identify potential juvenile delinquents, the five significant factors are: social assertiveness; defiance; suspiciousness; destructiveness; emotional lability (absent, slight or present).

Almost one-half of the book is composed of appendices, describing prediction tables, prediction factors, scores and definitions. There are special tables for male juvenile delinquents, for adult male offenders, for female offenders, for neurotic offenders, etc.

In Chapter X the authors report that two other groups of workers—in different parts of the country—using these prediction tables have been able to identify potential delinquents in at least 91 per cent of cases. A third research group has found positive correlation in 82.3 per cent of cases. In Japan a positive correlation was found in 89 per cent of cases, and in France in 91.2 per cent of individuals studied.

The reviewer is a clinician and finds it difficult to understand and follow all of the statistical material presented in this book. He does, however, consider this book to be another valuable contribution by two distinguished scientists who have devoted the major portion of their professional careers to the study and understanding of delinquents and criminals.

The book is recommended for teachers, lawyers, probation and parole officers, psychiatrists, legislators and particularly for judges of juvenile and adult criminal courts who bear the responsibility for sentencing the antisocial individual. If these prediction tables can be validated by more clinicians, one can do a great deal to identify and treat the potential delinquent or modify his environment to prevent his antisocial behavior. If he has been apprehended, the court worker using this predictive device can plan more intelligently how to plan for his future.

It is the reviewer's hope that this book will stimulate more study and research in this very significant area of human conduct.—FRANK J. CURRAN, M.D., New York, N. Y.

PSYCHODRAMA: FOUNDATIONS OF PSYCHOTHERAPY:

Second Volume

By J. L. Moreno

Beacon, N. Y., Beacon House, 1959, 236 pp.

This sequel to Volume I (which appeared in 1946) deals with what the author views as the foundations of psychotherapy—individual and group. There are six chapters, each consisting of a lecture, followed by from two to fifteen discussions and a "reply" by the author. Some idea of the scope of the book may be gathered from some of the chapter titles: (1) Transference, Countertransference and Tele; their relation to group research and group psychotherapy; (2) Interpersonal Theory; Group Psychotherapy and the Function of the Unconscious; (3) The Significance of the Therapeutic Format and the Place of Acting Out in Psychotherapy; (4) The Discovery of the Spontaneous Man, with Special Emphasis upon the Technique of Role Reversal; (6) Existentialism, Daseinsanalyse and Psychodrama with Special Emphasis upon Existential Validation. Among the discussants we find various points of view expressed by such writers as Ackerman, F. Alexander, Bromberg, Dreikurs, Fromm-Reichmann, Masserman and Sorokin.

Doctor Moreno, with his interest in sociometry and psychodrama, has contributed much to our thinking. Whether one agrees with him or not, he is always stimulating and provocative—useful traits in a

field in which there is much room for investigation and progress.

To Doctor Moreno "the fundamental principle underlying all forms of psychotherapy is the encounter (Begegnung, tele) and not the transference of psychoanalysis." Tele he defines as "insight into," "appreciation of," and "feeling for the actual make-up of the other person," thus emphasizing the two-way aspect of the therapeutic relationship.

The book may or may not make "converts," but it will certainly stimulate feeling and, hopefully, thought.—WINFRED OVERHOLSER, M.D., Saint Elizabeths Hospital, Washington, D. C.

MEDIEVAL AND RENAISSANCE MEDICINE

By Benjamin L. Gordon

New York, Philosophical Library, Inc., 1959, 843 pp.

The number of pages (843) in this book nearly equals the number of years that it covers. Its general discussions are easy to read: perhaps the general medical reader (not the historian) will skip the biographies of many lesser-known physicians.

One of the author's concerns is the way medicine—from the sixth to the thirteenth centuries at least—was promoted by the Arabian and Jewish cultures and hindered by barbarians and Christians. A fascinating example of Arabian knowledge is given in *The One Thousand and One Nights,* dated at the end of the eighth century. A beautiful and intelligent slave girl was questioned by the Caliph's physician and her answers have astonishing vitality today.

In separate chapters the slow growth of medicine in Europe is discussed for each country and for each disease. For the psychiatrist, the dancing mania, flagellation and the Crusades are in the chapter "Emotional Disorders."

The last chapter takes up the liberation of medicine in the universities after the passing of the Medieval Period.—EARL D. BOND, M.D., Philadelphia, Pa.

PSYCHOLOGY OF PERSONAL ADJUSTMENT: STUDENTS' INTRODUCTION TO MENTAL HYGIENE

By Fred McKinney

New York, John Wiley & Sons, Inc., 1960, 490 pp.

Professor McKinney has consistently pioneered in recognizing and in doing something about the importance of the college period for healthy personality growth. He has developed two complementary instruments to help students meet the problems incident to the transition from family dependence to adult autonomy: the professional counseling service and courses in personal adjustment for college students.

This third edition of a *Students' Introduction to Mental Hygiene* is a text for such a course.

The book is organized as a teaching text and complemented by an instructor's manual, replete with exercises. Its central theme is one of creative adjustment through self-understanding and active self-development. To form a basis for such efforts, a wide range of human behavior and experience is discussed, illustrated by cases which ring true and buttressed by copious references to some 874 carefully chosen studies. In effect it presents a psychological positivist philosophy of life for collegians, with the air of a wise and experienced, if slightly didactic, guide and mentor.

Whether this philosophy represents mental health is not critically examined—this

reviewer would prefer more questions and fewer answers—but the advice is reasonable except where it becomes too specific: e.g., to "buy a pocket notebook and determine useful, meaningful manner." Certainly Professor McKinney's book answers the need for a means to expand the psychological horizons of not too sophisticated college freshman, which may describe the majority.—BRYANT M. WEDGE, M.D., Yale University, New Haven, Conn.

CULTURE AND MENTAL HEALTH

By Marvin K. Opler

New York, The Macmillan Company, 1959, 533 pp.

Dr. Marvin K. Opler takes pains to emphasize that psychiatry, as a medical science, has perfected knowledge of patterned behavior in individual persons and in pathological states studied in western European cultures. The social sciences, working quite independently of psychiatry until recent years, have examined patterned behavior among groups of persons. The social sciences have noted ranges and contrasts in conduct, whether "normal" or aberrant, and anthropology, particularly, has extended these examinations throughout the world.

Recently, social psychiatry has begun to develop as a basic science concerned with the impact of cultural and social factors upon personality and human behavior. Through it the gap may be bridged between the converging fields of psychiatry and the social sciences, which are progressively recognized as useful to each other. *Culture and Mental Health*, a book of essays dedicated to the 1960 International Mental Health Year, illustrates the nature and degree of convergence thus far achieved.

The 23 authors are predominantly anthropologists or other social scientists; many of them have been directly associated with social psychiatry. (Several of them have also had personal analyses and have sometimes studied at psychoanalytic institutes.) Of the six physician-authors, five are psychiatrists. Additionally two of them have had formal training in a social science. The sixth physician holds a doctorate in public health, with studies in social psychiatry to his credit. All have concerned themselves with the social or ecological aspects of sickness.

The editor of this volume, an anthropologist who has worked in the field of social psychiatry for some 20 years, attempted to solicit essays that were based upon studies done in all the major continents and the Pacific islands. The purpose of the book, however, is not to present a round-the-world survey of mental health but to illustrate unequivocally the variable effect of culture or cultural stress on mental health. In this brief review it is impossible to do more than hint at the wealth of material that supports this thesis.

The two studies from Micronesia, for example, deal in one instance with contemporary "well" people and in the other with psychotic people. They have been grouped because they clearly indicate that both the healthy and the sick personalities "are moored in culture and subject to the conditions of culture existence." Fascinating essays about Chinese, Indians and Malaysians suggest that in addition to the differences in how mental illnesses are treated in various places, the amounts and types of disorder vary depending upon cultural factors. To mention one essay specifically as further illustration of the importance of cultural factors, "Family, Anxiety and Religion in a Community of North India" reports on the numerous religious rites by which the women annually propitiate gods and goddesses on behalf of their

husbands, sons and brothers. The purpose of this description is to emphasize the anxious concern that underlies the carrying out of these rites and to note how they reinforce the strength and importance of the Hindu family as a social unit.

Following the sections that focus on various contrasts drawn from Asia, Africa, Oceania and Europe, attention is directed to specific problems of subcultural groups in the United States: persons of Spanish-American, Irish, and Italian background, children of immigrant Jewish parents and American Negroes. Here the question of personality adjustment is of particular interest. These are groups whose members do not as yet identify themselves completely either with the dominant American culture or with their own minority culture (except for the Spanish-Americans in Texas, who are described in this book). They must, nevertheless, maintain ties with both. Differences in patterns of family authority, channeling of emotional expression and so on tend to make for serious mental conflicts. The conflicts may, however, manifest themselves in such unlike ways as those reported for the hospitalized Irish and Italian schizophrenic patients. Because of the caste system American Negroes have suffered more serious consequences than have these other groups. In his essay on "Explorations in Negro Personality," Dr. A. Kardiner declares that "psychiatry must treat individuals on whom the mark of oppression has been laid. It cannot do so without noting a subcultural variation which grows out of the discriminatory pattern."

The reader should not conclude from the foregoing paragraphs that the exclusive value of this book lies in its rich provision of helpful clews for psychiatric practice and further needed research, or of stimulating textual material for teaching. Perhaps its greatest potential usefulness lies in its implications for the planning and administration of programs of mental health and the institutional care of the mentally sick.

Differences in incidence, prevalence and type of disorder furnish a practical base, as Dr. Opler notes, for planning programs and "give insight into the necessary ingredients of preventive techniques." How little direct use has thus far been made of cultural knowledge, at least in psychiatric hospitals, is suggested in "Major Patterns of the Mental Hospital—U.S.A." by Dr. Edward A. Kennard, an anthropologist who has worked for several years in such institutions. He writes: "The grouping of patients has nothing to do with their previous social characteristics and experience. . . . Race, ethnic group membership, former occupational status and other indicators of expected social behavior are ignored. In this sense hospital life is discontinuous with all previous experience, with the possible exception of military service."—ESTHER LUCILLE BROWN, Ph.D., Russell Sage Foundation, New York City.

CHILD BEHAVIOR AND DEVELOPMENT

(Revised and Enlarged Edition)

By William E. Martin and Celia Burns Stendler

New York, Harcourt, Brace & Company, 1959, 618 pp.

This book is a revision of previous material. Both the revision and the enlargement, with its additional concepts, make the book far more useful. This text apparently was prepared for beginning students in child development. However it is

actually an excellent source book for anyone in this area as well as for those doing child guidance or other work with children. The authors are able to give a clear and well-substantiated picture of the development of the total child.

To the reviewer, the treatment of emotional aspects of personality and the space given to describing the socialization of the person is a welcome and very useful emphasis. The whole book is well-done although some of the material could do with a clearer and more simple explanation. Since the book is a revision, I will confine the remainder of the comments to the portions which were added.

Chapter Nine in Part II, I think, is a valuable addition. The importance of the experiences in the growing life of a person cannot be overemphasized where we are attempting to work with ways of increasing individual adequacy in getting along with oneself and one's fellows, and where we are trying to show parents and other adults ways of introducing experiences to the growing individual which will help him to make good reality adjustments more efficiently and quickly.

Another important part of this chapter is the excellent way in which the authors have drawn on research material to illustrate their points. They manage to make much of the animal research to which they refer show a very reasonable relationship to work with humans. They bring out in a very effective way the relationship of child development to different kinds of learning. I believe this chapter has greatly increased the value of the book.

With respect to Part IV, "The Course of Normal Development," the use of normal growth and development as a frame of reference from which to view the total growth of the individual is basically very important. In understanding human growth and learning, this frame of reference has been overlooked many times. The illustrations are clear and useful and, I believe, would be worthwhile to every level of reader. The space given to understanding cognitive development—motivational as well as physical development—has added greatly to the value of the material. Generally I have nothing but praise for this text even though many of the same comments could be made for Part IV that I made for the other new chapters—that more time and some more illustrations would have made this portion even more valuable than it is now.

The bibliographies and sources are good and varied and in themselves should be very useful to anyone wishing to go further with the material discussed in the text. It is the intention of this reviewer to use this book as a source book for undergraduate and graduate students and for laymen who wish to have a clearer picture of total development.—W. MASON MATHEWS, Ph.D., The Merrill-Palmer School, Detroit, Mich.

THE SEARCH FOR EMOTIONAL SECURITY

By Edward M. Bennett

New York, The Ronald Press Company, 1959, 239 pp.

This is an unusual book in one important way: it contains a distillation of sound psychological analysis and advice written in a consistently adequate way with no recourse whatever to technical jargon. The accessibility of the book to the nonprofessional reader is therefore very high, and one can recommend it highly to the informed and serious lay reader. It is not often that a book appears that combines clarity and

accessibility of writing with no dilution of content or analysis, and Dr. Bennett's achievement commands respect and, hopefully, emulation.

The framework of the book is an extended presentation of the life experiences of a striving middle-class male, Mark Rodgers, who, through circumstances essentially external to his basic life patterns, committed and was executed for a homicide. During the last few months of his imprisonment, Dr. Bennett treated him in almost daily counseling sessions.

The presentation of selected incidents and themes from Mark Rodgers' childhood, youth and early maturity is skillfully interwoven with discussions of the meaning of such behaviors in our society, the almost universal quest for security, the nature of child-parent relationships, the adolescent's struggle for identity, the adult's work and family roles and so on. The viewpoint is broad, with a constant and salutary reference to the inextricability of social and cultural factors in their effects upon individual psychology.

In sum, an unusual and useful set of variations on an important theme.—ALFRED H. KATZ, University of California Medical Center, Los Angeles, Calif.

SCORING HUMAN MOTIVES: A MANUAL

By John Dollard and Frank Auld, Jr.

New Haven, Conn., Yale University Press, 1959, 432 pp.

This book is a manual. It defines a way of marking off the sentence of a dialogue and, once they are marked off, of sorting these sentences into categories such as "fear" or "sex." One can count the number of items falling into each of these categories and say, for instance, that a specific hour of a case contains *n* fear sentences but no sex sentences. It may then turn out that a patient having *n* fear sentences and no sex sentences is a good prospect for therapy (or a poor prospect) and thus the time of good psychotherapists, always in short supply, can be more intelligently rationed. This, in a nutshell, is our project.

In a larger sense the subject matter is that of human interinfluencing or communicating, of signaling on the one side and responding on the other—of which psychotherapy is a special and critical example.

The reviewer could not put the descriptive aspects of this volume more succinctly than do the authors in their introduction.

This felicitous use of the language which the authors study by content analysis is a pleasantly outstanding quality of the book.

Content analysis is a very useful tool in attempting to study objectively and quantitatively such seemingly subjective and qualitative expressions as propaganda, advertisements and the communications of therapists and their patients. The crux of content analysis lies in the good definition and selection of variables. The authors provide a well-thought-out syllabus for the study of psychotherapeutic interviews.

As the junior author remarked in a lengthy review of content analytic studies of psychotherapy some years ago *(Psychological Bulletin,* September, 1955) we still need the intelligent application of content analysis within a conceptual framework. There is good reason to hope that the Dollard-Auld volume should lend itself to objective testing of basic hypotheses of psychoanalysis and other forms of psychotherapy.—LEOPOLD BELLAK, M.D., Larchmont, N. Y.

THE RORSCHACH AND THE EPILEPTIC PERSONALITY

(Le test de Rorschach et la personalite epileptique)

By J. Delay, P. Prichot, T. Lempérière and J. Perse

Translated by Rita and Arthur Benton.

New York, Logos Press, Inc., 1958, 265 pp.

Problems of the Rorschach test in the diagnosis of epilepsy, some of the problems of epilepsy itself and incidental information concerning the test in patients with brain pathology form the subject matter of this book. It consists of two major divisions. The first, comprising just about two-thirds of the entire book, is a survey of prior literature. The other and more important one-third reports on the authors' original investigation into this disease, one of the oldest recorded in the annals of man, yet ever-new in the riddles it poses.

These investigators studied 50 ambulatory epileptic persons of whom 13 were classified as suffering from "essential epilepsy." 14 as "symptomatic traumatic," 9 "symptomatic nontraumatic," and in 14 the cause was unknown. Ages ranged from fifteen to sixty, with a mean at 29.2. The sex distribution was 35 men and 15 women. The authors include brief notes describing the degrees of personality disturbance as severe, moderate or none.

In evaluating their Rorschach test findings the authors focus on four kinds of data. Three of these are known to students of the test. They are Rorschach's *Erlebnistypus* or the Experience Balance, the weighted sum of the color responses, and Piotrowski's 10 organic signs. The fourth consists of Minkowska's signs, i.e., certain relations among the forms seen as in movement. According to the authors, Minkowska finds these signs characteristic of patients with essential epilepsy. They themselves found such "relation" signs in 17 out of their 50 test records.

The findings in the investigation are reported in terms of statistics for the group, and their meaning is to be so gleaned from the numerous tables. However the authors always include enlightening exposition of their data, discussing them in relation to such factors as etiology of the epilepsy, localization of the traumatized area and the brain, and severity of the personality disturbances.

One general conclusion reached by the investigators was that Piotrowski's (Rorschach) organic signs "provide a positive diagnosis of epilepsy," (p. 229). These signs describe one of "two independent dimensions" derived from the Rorschach test protocols. Certain patients identified by these criteria make better social adjustments than others. A main general contribution from this investigation is in the test's support of the concept of "an epileptic personality."

From a Rorschach test point of view, a principal question is raised on the adequacy of the protocols themselves. From the statistics I infer a productivity of 15 or fewer scorable associations in 54 per cent of the patients. Of the two sample protocols, R is 22 in one and 5 in the other. A test protocol of five scorable associations is not one that can be interpreted in terms of personality. Rorschach set a minimum of 10 associations for the 10 cards. This reviewer prefers 12 to 15.

This investigation typifies in fact a central problem in reporting Rorschach test researches. The test explores the personality as an individual. Nomothetic statistical reports can only trace out tendencies in the groups, as such. But these are abstractions; they never describe the individual. Such a

research is therefore never completely reported unless it includes a sizable sample of the test protocols themselves and the diagnostic descriptions of the personalities as derived from these protocols. It is really impossible therefore to judge this book as a contribution on the test's clinical usefulness in epilepsy.

Assuming sound technical processing of the associations, the nomothetic statistics are critically essential for Rorschach test research. These statistics set up the parameters for the particular group in the several Rorschach variables. Only by having these nomothetic measures can we compare the findings in any one individual with those in his or another group, and delineate the features in him. Does he fit the pattern of epilepsy? I cannot agree with the authors, however, that the "presence of five or more organic signs" in a protocol "establishes the value of the Rorschach test as a positive indicator of epilepsy" (p. 210). Piotrowski's organic signs are found also in nonepileptic patients with brain pathology. As the writers themselves say, some of these signs are "those of the personality of organic patients in general and are not specific to epilepsy" (p. 233).

It is in the first two-thirds of the book—the survey of the literature—that we obtain an indication as to the present undefined situation in the test in this clinical group. The lacks of agreement stand out more than do the agreements or any definitive parameters that could be traced from them. Bibliographies with a total of 158 items enhance the reference value of the book. But in this connection, one puzzling question arises: how can a text be written on epilepsy without referring to Hughlings Jackson? His name appears neither in the bibliography nor in the index. Piotrowski has written an introductory commentary, and the smooth reading of the English text is a testimonial to the able translators, Rita and Arthur Benton.—Samuel J. Beck, Ph.D., The University of Chicago, Chicago, Ill.

GROWING UP TO LOVE, SEX AND MARRIAGE

By Sidney L. Sands, M.D.

Boston, Christopher Publishing House, 1960, 131 pp.

The author approaches the presentation of this important subject by a systematic discussion of psychosexual development from its earliest manifestations to maturity, when the person is ready to assume the responsibilities of marriage and parenthood. This serves as a basis for suggesting important guide lines for young parents and for growing children on how this process can be carried out most satisfactorily. It is most interesting to note the way in which the author goes beyond the early years of marriage and points out the changing patterns of marital settings in the middle and later years. The author stresses the point that man is unique in his ability to control the process of maturation through an understanding of both the roots of it and the process itself. The achievement of self-knowledge will enable the person to modify negative factors within himself and in his setting or lead him to seek help when he cannot achieve this result. Because of the dynamic nature of the growth process, it is never too late to strive for mature relationships and satisfactions.

The interpretation of the psychobiological concept of personality development is presented in terms which can be easily understood by a nonprofessional person. The literary style is excellent to a point where it is often difficult to remember that one is reading a factual treatise rather than a

piece of good literature. It is true that at times the author seems to set up ideal goals for which human beings should strive, but he makes it clear that these are ideals and the important thing is to strive to attain them.

The book should be particularly useful to adolescents, young people contemplating marriage and young couples still in the formative years of their married life. However, it is a book which can be read with satisfaction by anyone because of the deep conviction of the essential worth and dignity of the individual as presented in this highly worthwhile contribution.—WILLIAM MALAMUD, M.D., National Association for Mental Health, New York, N. Y.

PSYCHIATRIC DICTIONARY: THIRD EDITION

By Leland E. Hinsie, M.D., and Robert J. Campbell, M.D.

New York, Oxford University Press, 1960, 788 pp.

The third edition of this important volume is organized along essentially the same lines as its predecessors. It is more than a psychiatric dictionary. It is an encyclopedia of psychiatric, psychological, medical and other terms in current use in the professional field. There are 1,629 new listings, making a total of approximately 7,500 title entries. Following the word to be defined in brackets is a key to its pronunciation, its definition, origin and frequently a reference to source material. If an individual has a significant contribution to the subject defined, his name, the name of the publication, the publisher and the date of publication is given. Definitions are concise and presented in a way that professional workers should have no difficulty in understanding; for example: super ego, constitutional types and existentialism, which incidentally is a new term in this edition. In defining fears, nearly 200 terms describing various phobias are listed.

The narrative form in which material is presented is particularly interesting. One entire page is devoted to the Oedipus complex, and this is quite ample for most readers, although it would fail to satisfy the more serious student. Cross indexing is quite adequate. There is a brief note on important personages deceased since the publication of the second edition. This reviewer has enjoyed reading *The Psychiatric Dictionary,* not in its entirety to be sure, but to the extent that he recognizes and appreciates the valuable contribution the authors have made to the literature. As they state: "It is fundamentally useful to every worker in the field of psychiatry."—MILTON E. KIRKPATRICK, M.D., The Henry Pollack Memorial Clinic, Long Branch, N. J.

THE PSYCHOANALYTIC STUDY OF THE CHILD: VOLUME 14, 1959

Edited by Ruth S. Eissler, *et al.*

New York, International Universities Press, 1959, 433 pp.

This fourteenth volume continues the editors' tradition of carefully selecting papers which make a theoretical and clinical contribution to the psychoanalytic study of the child.

As in the past there are four sections. In the first one, on "Theory," I would like to mention the papers "On Isolation" by K. R. Eissler and Phyllis Greenacre's "Play in Relation to Creative Imagination." Both papers continue to draw on clinical investigation for the purpose of studying theoretical propositions. Greenacre continues to investigate—as so many have recently done

—the process of creativity by expanding it into the area of imagination.

In the next section, "Research Projects," you will find Anna Freud's studies, undertaken at the Hampstead Child Therapy Clinic. In this paper she discusses questions on analytic research methods and, as she put it, "the question of planned research in analysis." She gives the outline of her various projects—inquiries into the analytic treatment of adolescents and borderline cases, the study of blind children and those orphaned in early life. Many of these themes have gained clinical importance and I am sure all those interested in these topics will wish to acquaint themselves with these studies and their progress.

In the section on "Clinical Papers," I would like to point to Augusta Alpert's "Reversibility of Pathological Fixations Associated with Maternal Deprivation in Infancy." Here the author continues her work—published previously in other journals—on the effect of early maternal deprivation and the modification of treatment necessary to deal with deficiency disturbances in contradition to those which stem from "conflicts."

Also of interest is Anny Kata's "The Nursery School as a Diagnostic Help to the Child Guidance Clinic." The material came from the Department of Psychiatry of the Western Reserve School of Medicine. The author cites many clinical cases which illustrate the contribution nursery schools can make in the diagnosis of preschool children.

In the section on applied psychoanalysis, there is—among the four papers presented—Lili Peller's "Daydreams and Children's Favorite Books" in which the author shows the connection between what it is fashionable to read to children and their own imaginary world.

It is not possible to outline or to review in more detail such a collection of excellent papers. All those who know that the progress which psychoanalysis has made over the last decade is closely linked to the study of the child will find these volumes indispensable.—PETER B. NEUBAUER, M.D., New York, N. Y.

ALCOHOL IN ITALIAN CULTURE

By Giorgio Lolli, Emidio Serianni, Grace M. Golder and P. Luzzatto-Fegiz.

Glencoe, Ill., The Free Press, 1959, 140 pp.

This very thorough and accurate study was done in America, among Italo-Americans living in New Haven, Conn., and in Italy, principally among residents of Rome. The purpose was to compare the habits of the two groups.

The sample was devised so that people from all geographic sections of Italy were represented. The number of males and females in both groups breaks about evenly. There is a fair cross section of the population as far as professional status and economical level are concerned. Because about 99 per cent of the Italians are Roman Catholics, so were the persons considered in the present inquiry.

The difference between the two groups is appreciable only inasmuch as the Italo-American group has added hard liquors in some amount—still below the average of the American statistics—while the residents in Italy drink wine, beer only occasionally, and hard liquors in a very small amount. It is remarkable that even after two generations of life in the United States the habit of drinking wine and not placing emphasis on hard drinks is preserved. Cultural factors, and even more family tradition and religious practice, are responsible for this fact. The more serious clinical manifesta-

tions of alcoholism are infrequent. Wine is such a deterrent to the use of concentrated alcoholic drinks that its action is beneficial. Permanent and serious damaging effects of addiction to wine require such amounts of wine, drunk constantly for years, that percentage-wise, severe alcoholism in wine drinkers is far below the figures of comparable symptoms in hard liquor addicts.

But the most original and instructive part of the monograph is that devoted to the comparison between drinking and eating habits and how these influence and even determine each other.

The Italian pattern of a very light breakfast, a heavy noon meal and a lighter supper neutralize, to a considerable extent, the action of alcoholic drinks. Wine is the natural complement of the heavy noon meal. It is therefore assimilated with the meal—which essentially hinges on starches (noodles, potatoes and fresh fruit) and which is followed by a few hours of work, often manual—so that before the end of the day most of the alcohol has already been broken down and digested. The Italo-Americans, mostly of the second or third generation, have assimilated the culture and habits of the new country, and they indulge not only in hard drinks but also in the "cocktail hour," where drinks with higher alcoholic content than wine are taken with light food and followed by a period of leisure, devoid of muscular exertion. Even if the total amount of alcohol in a quart of wine is higher than the amount contained in a couple of cocktails, the amount of it metabolized as alcohol is larger, under the circumstances.

The monograph also goes into the interaction of wine and milk in the diet of the Italians and into the correlation between alcoholic and other drinks in the diet of the Italo-American group. The habits, well-examined in the study, are as decisive in their action as are biochemical considerations. The comparison between the two groups leads the authors to the conclusion that the Italians' habits are primarily responsible for the fact that in Italy alcoholism is a lesser social problem than in the United States, and this conclusion is corroborated by statistics.

After reading the book one cannot help feeling that there is an area in our knowledge of alcoholism which demands further study and clarification. The correlation between diet and consumption of alcohol, in connection with clinical manifestations of alcoholism, has not yet been thoroughly explored.—HECTOR J. RITEY, M.D., New York, N. Y.

PSYCHIATRIC SERVICES AND ARCHITECTURE

By A. Baker, R. L. Davies & P. Sivadon

Geneva, Switzerland, World Health Organization, 1959, 59 pp.

A new series called *Public Health Papers* has been inaugurated by the World Health Organization. The first of these, entitled "Psychiatric Services and Architecture," devotes some two-thirds of its pages to a restatement of the ideas and practices which cluster around the present-day vogue for community psychiatric services. The remaining pages of the pamphlet deal with broad architectural generalities recommended by the authors to those who would remodel existing buildings or undertake new construction in which mental health services are to be offered.

The treatise contemplates a continuum of assistance in the home, outpatient clinic, treatment center, day hospital, psychiatric unit of the general hospital, psychiatric facility, boarding home, sheltered workshop

and working settlement. The importance of adequately trained staff available in proper supply and deployed in the most effective manner is repeatedly and properly stressed for the success of such a program. With active treatment for every admission, the authors state: "All patients will respond to such an extent that a return to some useful function in the community is possible."

This rather surprising promise must, however, be understood in terms of the patient categories for whom other arrangements are recommended. Failing old people, for example, will be kept at home except in the few countries where the proportion of senile patients is so high that special provision for them may be necessary. Psychiatric patients with antisocial tendencies are to be treated in special facilities and "working settlements" will care for the class of patients—particularly those with schizophrenia—who do not recover sufficiently for a return to normal life in the community. It is not clear to this reviewer how such facilities will overcome the defects of the chronic psychiatric hospital, defects which the authors are quick to condemn.

They further state that they intend to "refrain" from making recommendations for the care of the alcoholic, drug addict, mental defective and epileptic patient. It seems reasonable to say that the complexion of existing mental hospitals in the United States would be considerably altered if these several categories of patients, particularly those with process schizophrenia, were removed without delay. One would hope that a subsequent publication by these or similarly knowledgeable and persuasive authors might confine itself to just these problem areas for, in the United States at least, they must be taken into serious account.

If "Psychiatric Services and Architecture" has a flaw, it might be said to lie in its level of generalization. The preface states with some pride that 29 psychiatrists from 13 countries and four architects from three countries made comments and amendments, thus increasing the international validity of the work done. Yet, in those passages of the report concerned specifically with architectural matters, the admonition is frequently offered that local conditions and custom must be fully taken into account. With this caution many would agree. An international document which contains only those generalities all can hopefully endorse may be in danger of sacrificing useful applicability for agreement in broad and innocuous principle.—PAUL HAUN, M.D., Trenton, N. J.

ADOLESCENT AGGRESSION: A STUDY OF THE INFLUENCE OF CHILD-TRAINING PRACTICES AND FAMILY INTERRELATIONSHIPS

By Albert Bandura and Richard H. Walters

New York, The Ronald Press, 1959, 475 pp.

This volume reports the results of an empirical study of the child-training factors and family relationships that are conducive to antisocial aggressive behavior in adolescent boys. The method is influenced by the tradition established by Robert R. Sears. It endeavors to merge the theoretical insights of psychoanalysis with contributions from the field of learning theory. Underlying the whole approach is Dollard's frustration-aggression hypothesis and the concepts of learning offered by Hull, Miller, Whitney and Child.

The study sets out to test a group of hypotheses concerning the relationships be-

tween dependency and anxiety, affection and sex, aggression and the establishment of internal controls. The subjects of study are 52 adolescent boys and their parents. Of these, 26 boys are of the aggressive type, and the other 26 represent controls. The process of data collections depends upon a series of individual interviews, after which the data are separately evaluated by three judges.

Examples of the hypotheses with regard to dependency and aggression are: parents of aggressive boys show less warmth and affection than the controls; parents of aggressive boys are less permissive of dependent behavior; aggressive boys display more direct aggression, conspicuously so toward mothers, less so toward fathers; aggressive boys show more anxiety in dependency situations; they are restrained more by fear than guilt.

With regard to sex and aggression, the following hypotheses apply: aggressive boys show less anxiety about sex than the controls; they engage more freely in heterosexual relations; they do not integrate sex and affection; their fathers are more permissive of heterosexual experience than those in the control group; aggressive boys have weak internal controls.

On principle, empirical investigations of psychodynamic theories are surely on the side of the angels. In this case, however, one cannot help but wonder what really has been achieved. The hypotheses are so general and clinically so self-evident that one wonders what is added to our knowledge with such statistical affirmations. The outcome of such measurements must surely be disappointing to the clinician. A study of this type tells us more about the limitations of a particular method of research than it adds to our understanding of human behavior.

If acting out in adolescent boys were viewed as a symptom of family distortion and if the interaction between mother and father were observed in interview, the results might have been more challenging. —NATHAN W. ACKERMAN, M.D., New York, N. Y.

PSYCHIATRIC NURSING CONCEPTS AND BASIC NURSING EDUCATION: PROCEEDINGS OF THE CONFERENCE AT BOULDER, COLORADO, JUNE 15–18, 1959

New York, National League for Nursing, 1960, 151 pp.

"The major purpose of the conference was to identify, study and evaluate behavioral science concepts and methods of integrating them. . . ." Principles, findings and concepts from the behavioral sciences that were described as concepts in the conference are identified as psychiatric nursing concepts in the title of this report. The four papers were in the areas of philosophy, individual supervision, basic components of therapeutic nurse-patient relationships and some of the basic concepts of psychiatric nursing. Each of these integration papers is followed by the discussants' papers and a summary of the general discussion.

A critical aspect of the initial paper on philosophy is that the authors have intended it to be a "statement in progress rather than a perfected statement of philosophy" underlying integration of psychiatric nursing concepts. "Individual Supervision" defines and describes one of the more recent methods of teaching concepts in psychiatric nursing which could be integrated in other areas of nursing in baccalaureate degree programs. "Identifi-

cation of the Components in a Therapeutic Nurse-Patient Relationship" identifies three of these components, several concepts and the phases of the relationship. The fourth paper, "Identifying Some of the Basic Psychiatric Nursing Concepts For Nursing Education," lists 10 statements as psychiatric concepts and discusses two of these.

The value of this report lies in the stimuli that are given to nurse educators and graduate students of psychiatric nursing in the areas of philosophy, a newer teaching method and further development of psychiatric nursing theory. Some of the intellectual tasks which might be accomplished by these persons are as follows:

1. Differentiation between concepts, principles, findings and processes;
2. Development of operational definitions of key concepts and principles of psychiatric nursing;
3. Development of methods of applying the key concepts and processes of psychiatric nursing;
4. Development of criteria by which the phases of nurse-patient relationship and the supervisory process can be identified;
5. Development of criteria which determine the content to be integrated; and
6. Further refinement of the philosophy underlying integration.

The goal of these and other tasks would be the communication of a theory of psychiatric nursing which could be applied, validated, refined and integrated.—SHIRLEY F. BURD, R.N., M.S., College of Nursing, Rutgers University, Newark, N. J.

Notes and Comments

MENTAL HEALTH WEEK, MONTH PLANS ANNOUNCED

The annual Bell Ringer Campaign for Mental Health will be launched during Mental Health Week April 30–May 6 and will continue throughout May. This year's Mental Health Week observance will feature the new Mental Health Careers Program of the National Association for Mental Health.

The week's special Careers activities will focus on both community and hospital programs — careers assemblies in high schools, library exhibits and careers meetings and conferences. Hospital-centered activities will concentrate on "Career Day" hospital tours as a part of the regular Operation Friendship program and on youth volunteer programs. Plans call for setting aside one special Career Day for hospital tours for young people, giving special emphasis to demonstrations of the different mental health professions and occupations.

The month-long fund-raising campaign will be chaired by Loyd Benefield, prominent Oklahoma attorney, and Jayne Meadows, television personality.

RESEARCH

The usefulness of tranquilizing drugs in preventing rehospitalization of chronic schizophrenic patients has been demonstrated by research recently reported to the Psychopharmacology Service Center of the National Institute of Mental Health. Follow-up studies of released mental patients have shown that under suitable treatment with the drugs it is possible for many patients who suffer relapse and would otherwise be hospitalized to live at home and in some cases to hold regular employment.

One study, designed to test the feasibility of treatment of relapsed patients within the community, was conducted last year by Dr. Else B. Kris, director of psychiatric research at the Research Unit of the Manhattan Aftercare Clinic in New York. Findings from this study are currently being used in an expanded study to compare the long-term effectiveness of drug treatment outside the hospital with the results of rehospitalization.

In another study, a four-year follow-up of 330 patients who were given courses of drug treatment after discharge from the Delaware State Hospital showed that only 14 per cent of those receiving the drug treatment suffered relapses which required rehospitalization, while 47 per cent of those not kept on treatment had to return to the hospital.

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A World Health Organization Expert Committee on Mental Health, which met in Geneva last fall, decided that research on an international as well as a national scale is necessary if further advances are to be made in preventing mental illness. The Committee defined areas of priority for mental health research, placing high on the list researches into brain function, social attitudes, effect of cultural change, psychoses of the aged, effects of nutrition and genetic factors.

It was suggested that research was needed on the kinds of stresses to which high policy makers and top administrators are subjected.

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Hillside Hospital in Glen Oaks, New York, has been awarded a new three-year research grant of $35,200 by the U. S. Public Health Service to make further studies on the metabolism of psychotropic drugs follow-

ing their administration to the mentally ill. The award has been made to Dr. Vivian Rishman, an associate in biochemical research.

CARE AND TREATMENT

Philadelphia State Hospital entered the area of ergotherapy (treatment through work) last fall. In November a program entitled the "Prep Shop," initiated by a small group of employees from several departments, was formally announced. The "Prep Shop" is designed to be one of the final readjustments of institutionalized life while aiming at the successful re-entry of the patient into the social and workaday world when he is released. A renovated building has been converted into an advanced but somewhat sheltered working situation.

Applications, interviews, screening and other industrial employment selection and psychological procedures are put to use to carefully choose the patients most likely to benefit from this type of activity. Accepted patients undergo a four-week probationary period during which they adjust and are rated as to interest, aptitude and progress. If retained, they are transferred from a preliminary to an actual workshop during the fifth week. At this time they are paid an hourly rate and undergo working conditions closely related to those encountered in the outside world.

Contracts are obtained from neighboring industry by personal contacts, direct correspondence and other methods.

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California's new day treatment center in San Diego represents a pioneering departure in the state's program for treatment of the mentally ill. The center will serve patients who otherwise would have to go—after some type of commitment proceedings—to a state hospital for 24-hour care. With the new type of facility, to which they are admitted as to any other hospital, they can be treated during the day and return home at night. Dr. Daniel Lieberman, chief deputy director of the state Department of Mental Hygiene, will direct the center through its first months.

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The first patients from the Rome, N. Y., State School have arrived at the school's new Mt. McGregor Division. When the renovations are complete the unit will accommodate approximately 400 patients and have a staff of about 200. The facility was formerly the New York State Veterans Rest Camp.

Buildings currently available for occupancy are suitable for selected types of older ambulatory patients. Facilities for children will be available as soon as the building formerly used as a rest home has been converted to an infirmary unit. Patients with relatives in the northeastern counties of the state are being selected for transfer so that the new location will be more convenient for family visiting.

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The Veterans Administration has made a number of recent announcements on newly established services for patients.

Prehospital and posthospital medical service now is authorized for nonservice-connected veterans where hospital stay can be shortened by these procedures. Thus better use of existing VA hospital beds is expected. For psychiatric patients, travel at Government expense, as required, may be provided to depart from and return to the hospital for necessary follow-up care.

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The VA has also reported a steady rise in the turnover rate of psychiatric patients in its hospitals. The yearly rate available for new patients has increased from 66 per cent in 1955 to 78 per cent in 1960. As a result the VA during the past year was able to admit more than 41,000 psychiatric patients to its hospitals. The agency now operates 58,668 beds for the care and treatment of these patients. Dr. J. F. Blasko, assistant director of the VA psychiatry and neurology service, said the increase results from extension of more intensive treatment to a larger number of the agency's mentally and emotionally disturbed patients. He also said the newer drug therapies in psychiatry have made patients more accessible to treatment and that findings of the VA's large-scale co-operative studies of these drugs have played an important part in developing the therapies.

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Music also is now being widely used by the VA as therapy for its mentally ill patients. For the catatonic patients special musical approaches are used, since the patients' retreat from reality is often marked by muscular rigidity and inaccessibility to ordinary methods of communication.

Sometimes familiar songs strike a response that helps them recall childhood memories or pleasant associations. Some VA hospitals have "catatonic motivation groups." A dozen men sit facing a piano and each is given a rhythm instrument. As the pianist plays, the men keep time to the music; a therapist goes from patient to patient to encourage them in their music-making. The interest aroused seems to help these patients become interested in other aspects of living.

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Major advances are being made in reducing rehospitalization rates of VA mental patients through the co-operation of hospitals and community vocational and employment services. A VA spokesman said hospitals where patients receive these intensive preparatory and follow-up services have reported readmission rates as low as 12 per cent, as compared with the 50 per cent rate for mental hospitals in the United States generally. These services include industrial therapy programs, night hospital programs, member-employee programs and family care programs and exit wards. The VA is now planning a national program of carefully controlled studies of hospital and community factors which best contribute to the vocational rehabilitation and employment of the mentally ill.

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Each day, five days a week, at least 180 persons register with the psychiatric outpatient clinics in New York City. Each day 155 cases are terminated by the clinics. Approximately 3,400 interviews, including group sessions, are held each working day with patients and their families. About 200 consultations regarding patients not on the clinics' rolls take place each week day between the staffs of the clinics and family physicians, teachers, nurses, counselors, and other professional personnel.

This profile of what goes on daily in the city's psychiatric outpatient clinics, based on 1959 figures of the 120 clinics operating as of December of that year, appears in the recently released annual report of the New York City Community Mental Health Board.

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Plans for the establishment of two new units for the care, treatment, cure and rehabilitation of narcotics addicts have been announced by Dr. Paul H. Hoch, New York State's Commissioner of Mental Hygiene. When set up, admission will be

made on both voluntary certificate and court certification. Dr. Hoch indicated that an 80-bed inpatient unit to serve the downstate area will be set up at Central Islip State Hospital, Long Island, and the other, a 20-bed inpatient unit, will be located at the Utica State Hospital to serve patients in the upstate area.

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The Fort Logan, Colo., Mental Health Center had its ground-breaking ceremony February 3. The new hospital, a part of the Colorado state system, will accept its first patients by the end of 1961. The program planned for the center envisions an institution which is closely integrated with local mental health clinics through which patients will come to the hospital. These clinics would also provide after-care and follow-up services.

TRAINING

The Department of Neurology and Psychiatry of the University of Virginia has announced the availability of a select number of residencies in psychiatry. A brochure describing this program in detail may be obtained from Ian Stevenson, M.D., Chairman, Department of Neurology and Psychiatry, University of Virginia Hospital, Charlottesville, Va.

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Representatives of 27,000 members of the National Association of Social Workers voted to adopt a certification program for professional social workers at the group's assembly in Chicago. They also approved a code of ethics which will be a condition of membership in the organization.

The certification plan provides that qualified social workers will be elected to an Academy of Certified Social Workers and may use the initials "A.C.S.W." after their names.

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California's Department of Mental Hygiene has inaugurated a program to aid in producing the registered nurses needed to staff state mental hospitals. Promising staff members who have served at least one year as psychiatric technicians may enter a two-year accredited nursing program at a nearby junior college to become qualified as registered nurses. During this period they engage in education at the college as they continue their work at the hospital. Participants enter into a commitment for two years of service at the hospital after they have qualified as R.N.'s.

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A course for mental health executives will be held at the University of Utah in Salt Lake City, June 5–30. The course is designed to train applicants for practical problems in mental health administration. Fees, room and board will be paid by a grant from the National Institute of Mental Health. Travel expenses for participants from 13 western states will also be paid by this grant. Additional funds are being sought to defray transportation costs for others. Interested persons may request application forms from the Utah Association for Mental Health, 132 East Second South, Salt Lake City.

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A program of postgraduate education in psychiatry for physicians in general medicine and other specialties is being organized jointly by New York State's Department of Mental Hygiene, the state Academy of General Practice and the state branch of the American Psychiatric Association, with the co-operation of the state medical society. The courses will be similar to the

seminars and one-day sessions conducted at the various Department institutions in the past and will include such topics as "Management of Psychiatric Emergencies," "The Use of Drugs," "After Discharge Care of Mental Patients" and other applications of psychiatry to general medical practice. Further information on the program may be obtained from the New York State Department of Mental Hygiene, Division of Community Services, 240 State Street, Albany.

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Establishment of a new position of training aide in New York's schools for the mentally retarded has been announced. Training aides will work with a limited number of severely retarded children of school age under the direction of the institution's education director. The initial group of aides will receive special training at Willowbrook State School, Staten Island, which will familiarize them with teaching methods and theory and offer practical teaching experience and critique in classrooms there.

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A post-doctoral training program in mental health research is now entering its second year. The objective of the program, which is under the joint auspices of the Harvard Medical School and the Massachusetts Mental Health Center, is to provide an intensive research experience in a specific field within the framework of an interdisciplinary approach to mental health problems.

Trainees must hold either the M.D. degree with three years of approved psychiatric residency, or the Ph.D. degree in the social, psychological or life sciences. Several traineeships are available to begin in July, 1961. Stipends of $6,000 for the first year and $7,000 for a desired second year are provided under a supporting grant from the National Institute of Mental Health. Applications and further information may be obtained from Milton Greenblatt, M.D., 74 Fenwood Road, Boston 15, Mass.

REHABILITATION

Ground has been broken for construction of a $2 million psychiatric rehabilitation center, The Gateways Hospital, to be located in central Los Angeles. The hospital, sponsored by the Jewish Committee for Personal Service, will operate as a sort of giant halfway house and will be both nonsectarian and nonprofit.

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Dr. Joshua Bierer, medical director of the Marlborough Day Hospital in London, has reported on the form and purpose of "therapeutic social clubs" in Great Britain.

He states that a number of these clubs have been in existence in Great Britain for the past 21 years, adding that neither staff nor patients feel that the clubs are only a means for "controlling" the patient once he leaves the hospital.

In Great Britain the therapeutic social clubs are not a part of after-care. They are part of the whole treatment, although they may be attended by patients who are no longer in active, individual, group or chemotherapy or even by patients who have not even begun treatment. In the day hospital setup the whole treatment is performed in the community and the sharp division between treatment and after-care is therefore nonexistent.

Dr. Bierer expressed his belief that therapeutic social clubs are not social gatherings for entertainment or resocialization but rather an opportunity for the psychiatrist and his staff—in co-operation with the patients—to create a special atmosphere

which is favorable to specific forms of treatment like individual group and social psychotherapy.

REPORTS, STUDIES, SURVEYS

The Des Moines Child Guidance Center recently completed its 1960 survey of salaries offered to various professions in mental health facilities. These facilities were selected on the basis of having staff members including at least one psychiatrist, one clinical psychologist and one psychiatric social worker. In 1958 survey questionnaires were mailed to all outpatient and inpatient health facilities listed in available directories as having a staff including at least one full-time person in each of these three professions. The 1960 questionnaire is essentially identical to that of 1958, the information included being obtained from 546 organizations.

The 1960 salary survey is available at $.35 per copy or $.25 per copy in quantities of 10 or more. Requests should be addressed to the Des Moines Child Guidance Center, 1206 Pleasant Street, Des Moines 14, Iowa.

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"The Frequency of Suicide" is the subject of a report in the December, 1960, issue of the *Statistical Bulletin* published by the Metropolitan Life Insurance Company of New York. The report states that suicide ranks eleventh among the causes of death; among white males, who account for about three-fourths of all self-inflicted deaths in the country, suicide ranks eighth.

The suicide rate is appreciably higher in the United States than in Canada. The relative frequency of suicide in the U. S. is several times that in Ireland, Northern Ireland, Greece or a number of Latin American countries. On the other hand, the U. S. suicide rate is no more than half that recorded in Austria, Hungary, West Germany or Japan.

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The country with the highest proportion of its population locked up in penal institutions is the United States, according to James V. Bennett, director of the Federal Bureau of Prisons. The rate is 120 adult prisoners for every 100,000 of the general civilian population. This report appeared in a recent issue of *Crime and Delinquency*, quarterly journal of the National Council on Crime and Delinquency.

One thing the courts can do to help solve the problem of overcrowded penitentiaries, says Mr. Bennett, is to refrain from using prison commitment when it is not necessary. Another thing that judges ought to keep in mind, writes Mr. Bennett, is the limitations of the institution to which they send an offender. He adds that the general availability of psychiatric service in prisons has been exaggerated. Of the 35 institutions in the federal prison system, only seven have psychiatrists on their staffs. A recent survey showed that there are only 32 full-time psychiatrists employed in all the state institutions for adult offenders. Fifteen of the 32 are accounted for by California; 38 states have no full-time psychiatrists employed in their institutions.

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Veterans Administration hospitals have begun a large-scale evaluation of six drugs used in the treatment of mental illness. More than 500 schizophrenic patients newly admitted to 36 hospitals will be involved in the 24-week controlled study. The drugs under evaluation in the new study are chlorpromazine, fluphenazine, reserpine, thioridazine, chlorprothizene and trifluprom azine.

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More dynamic leadership by state officials and the removal of restrictions on New York state financial aid to community mental health boards are major recommendations in a report made public recently.

The report, "Toward Community Mental Health" by Stanley P. Davies, is a review of the first five years of operations under New York State's Community Mental Health Services Act. The 225-page book was published by the New York State Association for Mental Health. It concludes that "The Community Mental Health Services Act is shown to have been soundly conceived. Experience to date reflects the wisdom and farsightedness of its drafters. The law is, and of course should be, larger in its scope and potentialities than any community has been able to realize. . . . The time has come after five years for the boards and directors to reassess their programs and to formulate or reformulate objectives toward a master plan."

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"After-Care Services in the United States," a progress report of state hospital programs is a new publication made possible by the Mental Health Education Unit of Smith, Kline and French Laboratories. The report is by Lee T. Muth, chief of social work service at the VA hospital in Huntington, W. Va. The report is based on the results of a survey made of 115 state mental hospitals, covering all states except Hawaii and Alaska. The results indicate significant progress in after-care services during the past three and one-half years.

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"When a society becomes disorganized and its people lose their sense of identity as a group," there is often an increase in the prevalence of mental disorder.

This is the finding of a study of the relationship between social factors and mental health being conducted by Cornell University as part of a program of social psychiatry which has taken social scientists to Mexico, Alaska, New York City, Nova Scotia and most recently, Nigeria.

The first and most comprehensive of the studies in the program is a 10-year program of research in Stirling County, Nova Scotia, where Cornell researchers have lived among the people, taking part in community activities, establishing a psychiatric clinic and gathering a wealth of material about social change and mental health. As a result of this study the scientists conclude that there is a definite relationship between the disintegration and disorganization of society and psychiatric stress—that when people lose their group identity and patterns of relationship, there is often a high prevalence of mental disorder.

A book reporting the background of this relationship has been released by Basic Books, Inc. It is entitled *People of Cove and Woodlot,* the second of three volumes on the Stirling County study.

LEGISLATION

Legislation to modernize the penal law and the code of criminal procedure in the defense of insanity has been introduced to the current New York State legislature. The proposed revision of the law will bring into line with present day psychiatric knowledge the definition of insanity and the determination of criminal responsibility. The bill amending the penal law provides that a person will not be liable for his criminal act if as "a result of mental disease or defect he lacks substantial capacity (a) to know or to appreciate the wrongfulness of his conduct; or (b) to conform his conduct to the requirements of law."

The companion bill proposes alterations in the code of criminal procedure to permit psychiatrists testifying in criminal cases to

give complete reports on their findings and whatever explanation they deem necessary to illuminate fully the psychiatric aspects of the case.

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From Election Day to Inauguration Day a number of advisory "task forces" appointed the then president-elect, were busy drafting recommendations for Administration policies in various fields.

The task force on health and social security was appointed "to review from among the most pressing and significant health and welfare proposals those which should have priority in the initial phase of the new Administration." It was headed by Professor Wilbur J. Cohen of the University of Michigan who has been appointed Assistant HEW Secretary for Legislation.

The task force recommended financing health care benefits for the aged through OASDI. Benefits would be limited "at this time" to inpatient hospital services, outpatient hospital diagnostic services, skilled nursing home services and "home health services." The task force further recommended that OASDI funds be used for community demonstration projects on development of health facilities and personnel needed to provide the new benefits or for consultative services to states regarding services and facilities utilized in providing the new benefits.

To increase the supply of health personnel the task force recommended a program requiring from $70 to $90 million in Federal funds during the first year and "about $270 million in the fourth year and thereafter."

To increase the facilities needed to provide the proposed new OASDI benefits the task force recommended: a $10 million annual increase under the Hill-Burton Act for facilities for long-term care including public and nonprofit skilled nursing homes and other facilities for the chronically ill: $100 million annually in long-term, low interest rate loans for construction or renovation of nonprofit nursing homes and hospitals, under approved state plans.

Creation by Administration action of a National Institute of Child Health within the National Institutes of Health was also recommended by the task force.

GRANTS

A grant of $35,134 has been given to Western Reserve University in Cleveland by the National Institute of Mental Health to initiate a series of studies directed at understanding some basic reasons for family strength.

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The first meeting of the newly-formed Psycho-Social Study Section, recently named by the Office of Vocational Rehabilitation to provide preliminary screening to applications for OVR research and demonstration grants in the areas of psychology and social work, was held in Washington recently.

This study section consists of nine persons prominent in the ranks of psychology, sociology and social work.

Two more study sections are in the formative stage. One will deal with projects in the fields of deafness, speech and hearing, and blindness and the other with projects concerned with the medical sciences.

APPOINTMENTS

The appointment of Philip E. Ryan as executive director of the National Association for Mental Health was announced recently by Mrs. A. Felix duPont, Jr., NAMH president. Mr. Ryan, executive director of the National Health Council since 1953, will assume his new post May 1.

In announcing the appointment Mrs. duPont said:

"Mr. Ryan's extensive experience and service in the fields of health, welfare and community organization will be a great asset at a time when strong and capable leadership is needed to help us expand our program, organizational strength and financial resources to meet the critical need for decisive citizen action in the fight against mental illness."

At the National Health Council Mr. Ryan has been at the hub of the health movement for the past seven years, helping national voluntary, governmental and professional health organizations work together in the common interest.

During World War II Mr. Ryan directed the world-wide foreign war relief program of the American National Red Cross. He was director of the Red Cross International activities until 1948 when he was appointed chief of the mission for the International Refugee Organization in the U. S. Zone of Germany.

In 1952 Mr. Ryan served in Korea as adviser on health, welfare and education in the U. S. Army civil assistance program.

A native of Waterville, Conn., he was graduated from Fordham University and received his M.A. degree at Notre Dame University. He has served on the faculty of the Catholic University School of Social Work and is author of the book *Migration and Social Welfare.*

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Constantine Stamatovich, M.D., has been appointed deputy assistant commissioner in the New York State Department of Mental Hygiene. Since April 1955 Dr. Stamatovich has been a supervising psychiatrist at Creedmoor State Hospital, Queens Village, N. Y.

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Dr. Stewart T. Ginsberg has been reappointed Indiana's state mental health commissioner by Governor Matthew E. Welsh. Dr. Ginsberg, former head of the psychiatric division of the Veterans Administration, accepted the top mental health post in Indiana in 1957.

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Mrs. Jacqueline Friend has been appointed executive secretary of the American Association of Psychiatric Clinics for Children. She will integrate and coordinate the various activities of the AAPCC and give advice and counsel to various community groups interested in the establishment of psychiatric clinics for children.

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Dr. Ernest M. Allen, chief of the Division of Research Grants and associate director for research grants at the National Institutes of Health, has been given full-time staff responsibility as associate director. The reassignment was brought about by the rapid growth and complexity of research grant activities of the Institutes.

Operating responsibilities for the Division of Research Grants will be carried out by Dr. Dale R. Lindsey who has been appointed chief of the division. Dr. Clinton C. Powell has been named deputy chief.

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Dr. E. James Anthony, a prominent British psychiatrist now living in St. Louis, has been appointed to the faculty of the Chicago Institute of Psychoanalysis.

AWARDS

Drs. W. Donald Ross and Frederic T. Kapp, professors of psychiatry at the University of Cincinnati College of Medicine, are the winners of the Franz Alexander Prize for 1960 for their contribution to psychoanalysis as embodied in their paper "A Technique for Self-Analysis of Counter-Transference."

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The Association for the Advancement of Psychoanalysis has announced the annual Karen Horney award. The award, in the amount of $150, is made for a paper deemed to have contributed significantly to the furtherance of psychoanalysis.

Authors who wish to enter papers should submit them no later than October 31, 1961. The recipient will be presented with the award on the occasion of the annual Karen Horney Memorial Lecture in March, 1962. All entries should be forwarded to Louis E. DeRosis, chairman, Karen Horney Award Committee, 815 Park Avenue, New York 21, N. Y.

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The Isaac Ray Lectureship Award will be continued for the years 1962–66 through the generosity of an additional grant of $6,000 to the American Psychiatric Association from the Aquinas Fund. The award is given annually to a psychiatrist or lawyer for outstanding contributions to furthering understanding the two professions. It carries an honorarium of $1,000 and obligates the winner to deliver a lecture series under the auspices of the law and medical schools of a university.

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Nolan D. C. Lewis, M.D., was awarded the first Emil A. Gutheil, M.D., Memorial Medical for Outstanding Contributions to Psychotherapy last fall by the Association for the Advancement of Psychotherapy. Dr. Lewis was a professor and chairman of the Department of Psychiatry, College of Physicians and Surgeons, Columbia University, and director of the New York State Psychiatric Institute from 1936–1953. Subsequently he was director of research in psychiatry and neurology at the New Jersey State Hospital in Princeton and research professor of psychiatry at Jefferson Medical College in Philadelphia.

MEETINGS, WORKSHOPS, CONFERENCES

The National League for Nursing will hold its annual convention April 10–14 in Cleveland. This will be a national forum on ways and means of improving nursing service and education.

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The annual meeting of the American Psychiatric Association will be held at the Hotel Morrison in Chicago May 8–12.

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The Annual Forum of the National Conference on Social Welfare will be held in Minneapolis May 14–19. The theme of this year's forum is "Concern for Human Welfare: Unifying Force for Survival."

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The Sixth International Congress on Mental Health will be held in Paris August 30–September 5. It will be the culmination of World Mental Health Year and will focus on the activities of that period. It will be appreciated if any World Mental Health Year activity not previously reported will be submitted to the office of the World Federation of Mental Health, 19 Manchester Street, London W. 1, in care of Mr. Paton.

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The World Federation of Neurology Problem Commission of Neurochemistry met in Antwerp for its second meeting last fall. The group endorsed the creation of a Panel on Neurochemistry within the framework of the International Brain Research Organization as a tool of great potential value in the advancement of neurochemistry throughout the world. The Commission also decided to organize a Symposium on Neurochemistry to be held in Goteborg, Sweden, in 1962.

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The Third World Congress of Psychiatry will be held in Montreal June 4–10 under the auspices of the Canadian Psychiatric Association and McGill University.

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The eighth annual meeting of the National Association for Gifted Children will be held in New York City April 26–29.

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On May 7 there will be a Conference on Existential Psychiatry in Chicago under the auspices of the Chicago Ontoanalytic Society and the American Ontoanalytic Association.

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The annual meeting of The Academy of Psychoanalysis will be held in Chicago, May 6 and 7.

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The Child Study Association of America will hold its annual conference and institute April 17–19 at the Hotel Roosevelt in New York.

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Education Extension, University of California at Los Angeles, has announced a five-week summer program in the education of exceptional children. Courses pertaining to the problems and education of emotionally disturbed children, the orthopedically handicapped and the mentally retarded, as well as those with speech handicaps, will be offered. The program is designed especially for teachers and for those preparing for work in the field of special education.

The dates are June 26–July 28. For information write to Mrs. Jerri Levin, Education Extension, University of California, Los Angeles 24.

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The New York Psychoanalytic Society celebrated its fiftieth anniversary on February 4. To observe the occasion the society invited psychoanalysts and members of related scientific professions to an afternoon program of scientific papers and an evening social session.

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The annual meeting of the Academy of Religion and Mental Health was held at the Hotel Biltmore in New York City January 19 and 20 with Dr. Harvey J. Tompkins, presiding.

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The annual meeting of the President's Committee on Employment of the Physically Handicapped will be held in Washington, D. C., April 27–28. The meeting will feature a session on advancing public understanding of the competence of former mental patients to return to positions of responsibility and service.

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The American Orthopsychiatric Association held its 38th annual meeting at the Statler Hilton Hotel in New York City March 23–25.

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A series of recommendations relating to mental health and mental illness emerged from the recent White House Conference on Aging.

The mental health section of the health and medical care workshop recommended: 1. The development of a public enlightenment program which recognizes that public attitudes toward mental illness can and must be changed; 2. The mentally ill aged should receive service in the community from the same agencies and clinics serving other groups; 3. The aged should receive mental hospital service only when they are mentally ill and there are psychiatric indications; 4. Mental health services, inpatient and outpatient, should be organized to

allow free movement of patients between services, depending on treatment needs; 5. The community should provide a proper psychiatric evaluation of any patient prior to initiating commitment proceedings; 6. Any plans which provide health care or assistance should not exclude the mentally ill.

Also of great interest to persons in the mental health field was the attention paid by conference delegates to the need for personnel in the mental health professions. A recommendation was made to step up efforts to recruit mental health personnel by developing programs that would ensure that able youth remain in school to prepare for technical and professional careers. It was also recommended that there be more emphasis on the humanities in high schools and colleges; that young people be used as volunteers in mental health programs; and that more realistic stipends be paid to mental health workers.

PUBLICATIONS

The Department of Health, Education and Welfare is now offering for public subscription a monthly periodical that features statistical measurements of social conditions and change. It highlights, on a month-to-month basis, the health status of the population, educational problems, social security and welfare programs, and vital statistics. Its title is *Health, Education and Welfare Indicators.* Subscription price is $3.50 per year, $4.50 if mailed to a foreign address. Orders may be sent to Superintendent of Documents, Government Printing Office, Washington 25, D. C.

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Koreans can now read the Clifford Beers book *A Mind That Found Itself* in their own language, thanks to the efforts of Dr. Suckjin Petrus Yoo. Dr. Suckjin, a clinical psychiatrist in Seoul, translated the book into the Korean language. Proceeds of the sales go toward the work of the Korea Mental Health Association.

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The Group for the Advancement of Psychiatry recently published its Report No. 48 entitled "Psychiatry and Religion: Some Steps Toward Mutual Understanding and Usefulness." Copies of the report are available at the following prices: $.75 each for 1–9 copies; $.60 each for 10–99 copies; $.50 each for 100 or more copies. Orders may be sent to the GAP Publications Office, 104 E. 25th Street, New York 10, N. Y.

ARTICLES SCHEDULED FOR PUBLICATION IN COMING ISSUES OF MENTAL HYGIENE

"Group Counseling with Expectant Mothers" by Nathan Hurvitz.

"Children in Crisis" by Warren T. Vaughan, Jr.

"Casework in Lower Class Districts" by Berta Fantl.

"Music in the Autobiographies of Mental Patients" by Dorothy Twente Sommer.

"A Study of the Criteria for Admission to a Psychiatric Ward" by Thomas L. D'Zmura.

"Psychiatric Case Finding in College by Nurse Interview" by Bryant M. Wedge.

"Attitudes toward Mental Illness, Anomia and Authoritarianism among State Hospital Nursing Students and Attendants" by James H. Williams and Helen M. Williams.

"A Brief History of the Narcotics Control Controversy" by Jack Zusman.

"Interpersonal Dimension in International Technical Assistance: Statement of a Problem" by Sven Lundstedt.

"A Motivation-Hygiene Concept of Mental Health" by Frederick Herzberg and Roy M. Hamlin.

"Recreation and Mental Health" by William E. Morris.

"A Health Group Life-Social Group Work's Contribution to Mental Health" by Gisela Konopka.

"The Secret of Medical Practice" by Leo H. Bartemeier.

"The New Generation of Ex-Patients" by Gertrude L. Nilsson.

"Escapes from a Mental Hospital" by Robert Dewar.

"An Exploratory Study of Culture Change and Mental Health Among Certain Filipino College Students" by Jerome G. Manis and Laura G. Manis.

"An Investigation of Problem Areas Relating to the Therapeutic Community Concept" by La Verne F. Irvine and S. Joel Deery III.

"Patterns of Membership in a Self-Help Organization in Mental Health" by Henry Wechsler.

"Some Considerations of Acting Out Behavior in Nursing Situations" by Ruby A. Palmer.

"The School Administrator's Mental Health" by Herbert A. Otto.

"Some Reflections on Learning and Personality" by Louise L. Tyler.

"The Posthospital Psychological Functioning of Former Mental Hospital Patients" by Mark Lefton, Simon Dinitz, Shirley Angrist and Benjamin Pasamanick.

"Social Problems of Mentally Retarded Children" by Mildred W. Barksdale.

"Changes in Attitudes toward Mental Illness" by John Altrocchi and Carl Eisdorfer.

"Mental Health Programs in the Decade Ahead" by Mathew Ross.

"The Effect of Family Moves on Children" by Robert E. Switzer, J. Cotter Hirschberg, Leila Myers, Elizabeth Gray, Nathaniel H. Evers and Robert Forman.

"A Layman Leads a Great Books Group in a Mental Hospital" by Lawrence M. Seiver.

"One Step at a Time" by Betty Blass.

"Social Therapy through Hospital Ward Discussions" by Sherman N. Kieffer, Mary G. Monteiro and Lillian M. Snyder.

"How To Act toward Emotionally Disturbed Neighbors, Friends and Relatives" by Mathew Ross.

"Open Ward Management of Disturbed Mental Patients of Both Sexes" by Magno J. Ortega.

"Attitudes of Nursing Students toward Psychiatric Treatment and Hospitals" by Laura C. Toomey, Marvin Reznikoff, John Paul Brady and Dwight W. Schumann.

"Fundamental Facts Relating to the Counseling and Higher Education of Epileptic Persons" by F. Leslie Kammerdiener, Jr.

"The Role of Education in a Residential Treatment Center for Children" by Povl W. Toussieng.

"Young Indians: Some Problems and Issues of Mental Hygiene" by Elizabeth E. Hoyt.

"Trends in Soviet Psychiatry" by Alex H. Kaplan.

"Some Pre-World War II Antecedents of Community Mental Health Theory and Practice" by Ascanio M. Rossi.

"Psychiatric Aspects of Police-Community Relations" by Chester M. Pierce.

"Role Reversal in Geriatrics" by Arthur L. Rautman.

"MMPI Changes Following a Course in Mental Hygiene" by Frank Kodman, Jr. and Gordon Sedlacek.

"The Inadequate Chronic Alcoholic Personality" by Edward Podolsky.

"Are Monthly Meetings of Chapters of the Mental Health Association Necessary?" by Loyd W. Rowland.

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NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a co-ordinated citizens' organization working toward the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health.

William Malamud, M.D.
Acting Executive Director
Professional and Research Director